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WELFARE in REVIEW

APRIL 1967
Volume 5 Number 4

President Johnson's Message on Children and Youth

Poverty and Family Planning

Extending Child Welfare Services

U. S.
DEPARTMENT
OF HEALTH,
EDUCATION,
AND WELFARE

Welfare Administration

Children's
Bureau

Bureau of Family
Services

Office of Juvenile
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U. S. DEPARTMENT OF
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A Brighter Promise For America's Children

WILBUR J. COHEN*
Under Secretary of Health, Education, and Welfare

"Our goal must be clear--to give every child the chance to fulfill his promise."

President Lyndon B. Johnson issued this clear directive February 8 in his special message to Congress on America's Children and Youth.

To fulfill a brighter promise--to offer to all children the fullest possible access to opportunity and advancement--the President recommended an imaginative 12-point program calling for:

- Strengthening Head Start and preserving its opportunities in a follow-through program in the early grades of school
- A Head Start program for even younger children than are now being helped
- A pilot lunch program for ill-nourished children
- The creation of child and parent centers in areas of acute poverty to provide modern and comprehensive family and child development services
- The training of specialists to deal with the problems of children and youth
- Improvements in programs providing aid for children in poor families
- Increase in Social Security payments for children already covered
- Expansion of programs for early diagnosis and treatment of handicapped children
- A continued attack on the problems of mental retardation
- A pilot program of dental care
- New approaches to the problems of juvenile delinquency
- The enrichment of summer programs for needy boys and girls

The grim statistics which follow point up the plight of millions of children in America--children doomed to a poverty so rooted, so self-perpetuating, that they form a permanent pocket of despair in the midst of our general abundance.

Of the 32.7 million Americans living in poverty, almost half of them--14.5 million--are children. Another 5.3 million are elderly citizens. Six and one-half million families are poor because the heads of their households are unable to work: either aged, severely handicapped or they are widowed or deserted mothers with young children.

Many children are living in city and rural slums. They lack adequate housing and health facilities and have few recreational activities.

Children are among the most tragic victims of the tensions of modern life. An estimated 10,000 are mistreated by parents each year. Thousands of others are being reared in broken homes in which they receive too little care because parents are mentally ill or retarded or in trouble themselves.

Although over one-half million children benefit each year from the services of professional child public welfare workers, there are still children in more than 1,000 counties in the United States without any child welfare services. Other counties have too few workers. In some large cities abandoned babies remain in hospitals because of the lack of home finding services.

The health of many of the Nation's children has also been neglected.

- Last year there were about 90,000 infant deaths.
- Each year 125,000 infants are born mentally retarded.
- Over a third of the preschool children who need treatment for eye

*Mr. Cohen was recently designated by Secretary John W. Gardner as the Chairman of the Committee on Children and Youth which will oversee and coordinate the Department of Health, Education, and Welfare's programs and activities affecting the Nation's youth.

difficulties do not see a doctor; three million children who need glasses today do not have them.

Among poor children the number of conditions that remain untreated is far greater than among children of upper-income families.

- In low-income areas, 6 out of every 10 children who suffer from one or more chronic conditions are not receiving any treatment.
- Families with dependent children comprise over half the people who receive public assistance but only a small proportion of the public assistance funds spent for medical care has benefited these families. There are today 3.5 million poor children under 5 years of age who need medical help but do not get it under public assistance programs.
- Sixty-five percent of the Nation's poor children between the ages of 5 and 14 have never seen a dentist, although tooth decay attacks 97 percent of all children by age 5 or 6.

Improving Child Assistance

The President's message underscored one of the most pressing problems facing us today: that of providing more adequate financial support for needy children.

In 1966, 3.2 million children living in families too poor to feed and house them adequately received Federal financial help under the Aid to Families with Dependent Children program. Another 10 to 12 million children needed additional income.

The President has recommended substantial improvements in benefits for children under both the Social Security program and the AFDC program. The impact of poverty on children and youth takes its toll in terms of health, education, housing and many other areas of life. All resources must be brought to bear to break the vicious cycle of poverty.

It is essential that the tide of neglect be reversed. The Nation's future is dependent on the present prospects of youth. They are the ones who will bear the future responsibilities of an increasingly complex world. By 1970, more than one-half of the population of this country will be 25 years old and younger--over 100 million children and youth.

The recently-formed Committee on Children and Youth of the Department of Health, Education, and Welfare emphasizes Secretary John W. Gardner's determination to focus the Department's attention on programs and activities aimed at developing the potential of young Americans. Strengthening existing programs which aid children and youth and considering innovative proposals to meet their needs in the decade of the 70's will be among the Committee's chief concerns. The Committee will also be involved in planning for the Seventh White House Conference on Children and Youth to be held in 1970. Since 1909 there have been six White House Conferences, bringing together representatives of all agencies and institutions concerned with the health, education, and welfare of youth. Many recommendations of these Conferences have been put into effect--for the benefit of the Nation--at the Federal, State and local levels.

In our efforts to help every child advance according to his interests and abilities, it is with the youngest of the children of the poor that we must start--and start without further delay. For here is where the hope of fulfillment is the greatest, and if, as in Head Start, they are reached early enough and care and attention are given long enough, where the greatest success can be achieved.

The President's 12-point program is a significant step forward. Throughout the message there is a sense of urgency: that we begin *now* to fulfill a brighter promise for America's youth. "We look toward the day," the President said, "when every child no matter what his color or his family's means, gets the medical care he needs, starts school on an equal footing with his classmates, seeks as much education as he can absorb--in short, goes as far as his talents will take him."

To elude the opportunity to help every youngster realize his or her fullest potential would be, in the final analysis, to dim the potential strength and progress of the Nation.

POVERTY AND FAMILY PLANNING IN THE UNITED STATES

Some Social and Psychological Aspects and Implications for Programs and Policy

CATHERINE S. CHILMAN*

The first part of this article contains a summarized overview of the findings from selected social and psychological research related to poverty and family planning in the United States. The second section deals with some of the implications of these findings for principles and practices in family planning programs, while a brief third section is devoted to some suggestions for further experimentation and research. The major purpose of this effort is to provide practical guides to professional personnel in the fields of family planning program development, practice and action research.

The need for family planning programs in this country, from the viewpoint of population pressures, is not presented. An earlier article in *Welfare in Review* dealt with this topic.[1] The medical aspects of family planning are also omitted because they are presented adequately in a variety of other publications[2] and because they are beyond the scope of the author. It is recognized, however, that the medical component is central to the implementation of any family planning program. Contributions from the social and behavioral sciences are supplementary and supportive.

I. SUMMARY OF SELECTED SOCIAL AND PSYCHOLOGICAL RESEARCH

The chief sources of social and psychological research related to family planning and poverty in the continental United States derive, for the most part, from four major kinds of investigations: (a) studies of knowledge, attitudes and practices regarding family planning,[3-9] (b) census data, (c) in-depth studies that might be considered anthropological in nature,[10] and (d) experimental action studies.[11,12] While the focal point is the continental United States, other countries are also highlighted when evidence from research studies abroad yield important insights.[13,14]

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For references, see end of article.

Some Limitations of Studies

All of these studies provide helpful information. The first group is the most extensive but presents certain limitations in terms of providing a national, current picture of family planning knowledge, attitudes and practices of all relevant segments of the population.

1. These studies are limited, for the most part, to married couples only.
2. Most of these investigations refer to a point in time which might now be called "antique"--i.e., before the simpler forms of contraceptives (the oral contraceptives and the intra-uterine device) were widely available and in general use.
3. Three studies refer to only one city[3,4,7,8] and one study is almost 30 years old.[3]
4. One study focuses on formative families that are still small (two children).[5]

5. Most studies do not make fine enough distinctions between working class and very poor groups (unemployed or underemployed casual laborers).
6. The nonwhite samples are either not included or are very small.
7. Women are the chief correspondents for the majority of these investigations.

Census data have been helpful in providing broad pictures of the relationship between family size and education, occupational level, income, marital status, and type of area (urban, rural, etc.). Of course, these data cannot provide in-depth information about such factors as attitudes, aspirations, contraceptive practices and the like.

The *in-depth studies* related to the topic of family planning[10] provide insights and clues; they are limited, however, by lack of a national sample and by lack of scientifically rigorous research designs and statistical analysis of results.

Experimental action studies that involve the use of newer forms of contraceptives, such as the "loop" or the "pill," are still in an early stage of development in terms of the numbers and kinds of experiments that have been carried out and completed to date. However, these studies offer considerable promise for the future, in providing guides to effective ways of setting up and operating family planning programs designed to reach those who have particularly lacked such services in the past, i.e. very poor families of rural residence or recent rural background.[6]

Psychological Studies. Only a few studies have attempted to get at such psychological factors as personality characteristics of persons who favor or disapprove of family planning or of persons who prefer large or small families. These investigations have failed to provide any clear-cut results. This failure may be associated with the lack of coherent theory on which some of the studies were built.[3] In one instance, problems may relate to the nature of the sample itself (couples still in the early process of family formation) and to the kinds of personality tests used.[5] In other earlier psychological studies, the methods of personality testing were still too rudimentary to yield satisfactory results. However, even today, reliable and valid methods of personality assessment for research purposes are still in their early and less-than-satisfactory stages of development.

A host of speculative theories have been advanced--mostly by behavioral theorists and clinicians--as to the psychological factors involved in the desire for no, a few, or many children. Hypotheses based on these theories have tended to cluster around such concepts as female anxiety over adequate sexuality, female resistance to woman's sex role, male concerns to prove virility, infantile impulsiveness and so on. There is, however, no research evidence to support these "hunches" and it is highly probable that psychological factors alone[3, 5] do not account for attitudes and behaviors in this matter. Family size preferences apparently are a complex matter involving interactions of psychological, physical, cultural, religious, economic and situational factors operating in the dynamic context of family life. In this context, the multiple characteristics of both husband and wife in their relationship with each other are among the salient factors that must be considered.

Studies of Life Styles of the Poor. Along with the social and psychological studies that have been specifically concerned with family planning, other important although somewhat indirect sources of evidence lie in investigations that have been concerned with: (a) the child-rearing and family life patterns of the very poor and (b) social and psychological factors associated with marital stability.[15]

Major Findings of Social Research Related to Family Planning

Despite the gaps and limitations in research-based knowledge, a good deal of information is available which should be useful to practitioners, administrators

and researchers as they seek to develop effective family planning programs. Therefore, a summary of the major findings from related social and psychological studies is presented below.

1. The great majority of people in the United States (about 90 percent) approve of the concept of family planning. [3-12]

2. At all socioeconomic levels in this country and in other countries studied--including some of the so-called disadvantaged nations--the average number of children desired is between two and four. [5-7, 13, 14]

3. The arrival of the fourth child seems to represent a critical point for a family. Even for those relatively few families which had previously expressed a desire for more than this number of children, this wish is apt to be revised after the arrival of the fourth child. [6, 7, 14]

4. Evidence is beginning to emerge that families with more than four children, even when controls are established for differences in socioeconomic level, are less likely to be viewed by the children as happy ones [16] and are less likely to produce self-reliant, outgoing youngsters who achieve well in school. [17] However, further studies are needed in this area, with careful consideration of possible associated variables, before one can be confident that family size plays such a crucial role.

5. The basic reason for limitation of family size given by couples in the United States and other countries is an economic one. [7, 10, 13] It is closely tied to a desire to provide a better quality of life for one's children. Considerations of maternal and child health are rarely given by respondents.

6. In this and other countries, desire for small families and for effective contraceptive practice is highly associated with: urbanization, education (in the United States, more than an eighth grade education) and high aspirations for one's children. In this country, however, urbanization has failed to have the sharp, distinctive impact on desire for small families and related contraceptive practice that was anticipated by urban sociologists. These anticipations were based on the experiences of Western European countries and Japan and on theories of urbanization. Urban and rural families in the United States are highly similar in generally wanting between two and four children--and in having this number of children. The distinctively different group consists of those families living in the rural South and recent urban migrants from that region, especially nonwhite families. Although this group generally aspires to a small number of children, there are high rates of contraceptive failure.

Among the reasons for the general lack of differences in desired family size between most urban and rural people in this country may be: the high level of income available to most families; the growing urbanization of rural areas through improved transportation facilities, the availability of mass media and the mechanization of most farms; and the suburban and "exurban" living of numbers of our so-called urban families. It is well known that the suburban and exurban style of life is generally a family-centered one.

The relatively greater poverty, isolation and racial segregation of the rural South probably play a large part in the different family planning attitudes, information levels and practices found in this region. The severe problems of the urban in-migrants from the rural South and their isolation in the poverty "ghettoes" of the city (particularly in the case of the nonwhites) are directly related to their difficulties in family size limitation.

7. Poverty has a cluster of causes and effects that interact with, and exacerbate, each other. Cause and effect are so intertwined as to make it impossible to know which is which. The following are factors which are strongly associated with the poverty of families: low educational level of parents, lack of job skills, rural residence or rural origins, female-headed families, illegitimacy, minority group status, early marriage, children spaced closely together and large family size--especially families with five or more children.

8. Large families increase the problems of the very poor: a small income has to be divided into even more parts; harassed and inadequately prepared parents experience an added number of pressures; children suffer extra amounts of economic, physical, social and psychological deprivations; housing and homemaking problems are increased; the marriage is likely to be strained to the breaking point; and a new generation of children grow up with a tendency to be trapped in poverty and failure.[1]

9. Difficulties in effective family planning on the part of very poor people relate to the above and to the following factors: lack of money to pay for family planning services, isolation from such services, lack of relevant information, and their life-style (or subcultural) patterns.[15]

10. Contrary to much popular opinion, very poor people do not want large families; they simply have more difficulty in effective family planning.[4, 6, 10] Again, contrary to popular opinion, very poor families are not resigned to poverty for themselves and their children; particularly for their children they want the same things that other more fortunate parents want: a good education, good health, respectability, a secure and satisfying job, an attractive home and a happy marriage.

11. The life styles more typical (but *not* typical) of the very poor include elements that create a variety of problems for them and tend to stand in the way of their movement out of poverty. The conditions of poverty account, to a large extent, for these patterns, but these patterns tend to interact with adverse conditions to tighten the poverty trap. These life styles affect family planning attitudes and practices in a variety of ways. Attitudes of fatalism, magical thinking, personalism, apathy, lack of time orientation and hostile alienation from the more advantaged sector of society--especially its social institutions and authority figures--tend to stand in the way of active planning for marriage, child-spacing, family size and future goals for one's self and one's children. A lack of commitment to and faith in schools, clinics, social agencies, religious institutions and the advice and services emanating therefrom frequently prevents the use of such services. These attitudes also tend to undermine a belief in the efficacy of contraceptive methods. Such families which do use contraceptives tend not to start using them until they have had three or four children and then to use them sporadically.[6, 10]

Resistance to active participation in family planning on the part of very poor families was much higher before the introduction of the simpler, less expensive contraceptive methods, such as "the pill" and "the loop." These methods, unlike earlier medically recommended ones such as the diaphragm, do not require specific preplanning regarding sex relations and direct communication and cooperation between marital partners. Moreover, these methods are easier and cheaper to use and are not so likely to require a knowledge and understanding of the physiology of human reproduction. Programs for low-income families which offer these newer methods are experiencing a far higher rate of sustained clinic attendance than was true in the past. Yet many people still are not reached, a number of patients drop out of the program and a number of unplanned births occur. Further efforts are required to help low-income groups achieve their goals of smaller families.

12. Other aspects of family life styles more prevalent among poverty groups are associated with their problems in family planning. A series of studies[10, 18-21] indicate that:

a. A larger proportion of working-class and middle-class families than very poor families report happy marriages and mutually satisfying sex relationships.
b. Low-income men and women tend to live in quite separate social and psychological worlds with very little communication between husband and wife, whereas communication and shared activities are

clearly related to marital happiness, and sex satisfaction and communication and marital happiness are closely associated with effective family planning.

c. Hostile and mutually exploitative attitudes are likely to obtain between the sexes in low-income groups; the male tends to play an authoritarian role in the family; a larger number of marriages are broken by divorce, desertion and separation; very poor people have extremely limited knowledge about sex, reproduction and childbirth.

d. Sex relations--both in and out of marriage--are likely to be seen as proof of one's prowess as a man or woman rather than as a part of an interpersonal relationship. Peer group pressures for premarital and extramarital sex experiences are strong.

e. Parents are apt to fear giving sex education to their children in the belief that this may lead to "trouble."

f. Illegitimacy is regarded as undesirable, and there is a marked preference for marriage if the opportunity for an economically secure and satisfying marriage presents itself.[23]

The very poor tend to adapt their values regarding sex to the conditions of poverty where jobs for men are scarce and wages are low, where public assistance policies in some States forbid aid to families in which an able-bodied man is present in the home, and where the struggle for existence often breeds an atmosphere of fear, violence and despair. The seeming impulsiveness of many of the very poor probably springs more from a depressed "can't care" attitude than an irresponsible "don't care" approach. Apparent sex freedom is more likely to be a symptom of underlying loneliness and hopelessness about one's self and others than a positive search for pleasure. The sex-related problems more characteristic of the very poor are apt to be a presenting symptom of the more basic cluster of problems that go with their disadvantaged life situation.

Life styles of the sort discussed above have been found to be associated with extreme poverty in such areas as Puerto Rico[22-25] and other Caribbean islands as well as in the continental United States. Although there are minor variations of these life styles from region to region, evidence is mounting that such patterns are strongly associated with poverty itself, wherever poverty exists.

13. The *conditions* of poverty are not the only factors creating the life styles frequently found among the very poor. The life styles of the more advantaged also play a part. Their attitudes toward the poor help to shape the attitudes of poverty groups towards themselves and the outer world. Fatalism and apathy *about* poor people, rejection of them as worthy human beings, separation and alienation *from* them, punitive attitudes toward their problems: middle-class life styles of this sort help to create the separate and troubled worlds of the very poor.

14. Nonwhites, compared to whites at the same poverty level, are more apt to suffer from the foregoing problems. Many explanations are advanced for this, including the fact that a larger segment of the nonwhite population is very poor and more nonwhites are recent newcomers to cities. The effects of prejudice, discrimination and cumulative disadvantages over many generations on cultural patterns and personality formation[10, 26] are not given enough serious recognition by many writers who discuss the marital and family problems of nonwhites. Although in some respects the situation of nonwhites has improved in recent years, the social-psychological effects of the past are not easily erased.

15. Women who are employed in the labor force, at all socioeconomic levels, are apt to have small, planned families. This is not chiefly associated with fertility problems but is more related to aspirations of the family for a higher standard of living.[7] It is also (probably) related to the fact that these women have found

broader interests and a sense of personal significance through a range of experiences that go beyond having a large number of children.

16. Experimental programs designed to test the effectiveness of various methods of reaching very poor families with family planning services point to the conclusion that the person-to-person approach is the most effective, especially when the person has apparent competence in such professional fields as medicine or social work, and a warm, outgoing empathetic manner. Well-informed, enthusiastic members of the poverty group itself have also proved to be highly effective communicators concerning family planning.[11,12] Communications via the mass media or special mailings in low-income neighborhoods tend to be helpful in shaping general community opinion and reinforcing the knowledge and convictions of persons already using family planning services. Such publicity efforts, however, apparently have little effect on those highly disadvantaged people who wish to plan their families but who are held back from initiating action through their lack of education, low reading ability, fear, distrust and sense of rejection by society.

II. SOME IMPLICATIONS FOR FAMILY PLANNING PROGRAMS

Suggested Principles

Certain basic guiding principles for the operation of family planning services for low-income groups would seem to flow from the social and psychological research summarized above. In developing these suggested principles, the author has also drawn selectively on more basic social and psychological research and theory. These principles are presented as suggested guidelines, and it is recognized that others may emerge as further research becomes available. It is also recognized that these principles need to be coordinated with those that derive from the field of medicine. Moreover, principles are theoretical in nature; their application requires many kinds of adaptation to specific situations.

1. Since social, psychological and economic factors strongly affect family planning knowledge, attitudes, and practice, a comprehensive approach to family planning services would seem to be indicated. This approach would include educational, economic, social and psychological, as well as medical services.

2. These services need to be coordinated and based on a recognition that human behavior is derived from an interaction of physical, social, psychological and economic factors. Such programs would have a wider potential than simply that of helping parents to fulfill their aspirations in reference to child-spacing and family size. They would also seem to offer an opportunity for helping fathers and mothers to improve all aspects of their marital relationship and to provide their children with better guidance in the area of family life and sex education.

3. Since communication and sharing between the sexes appear to be so important to marital happiness, family stability, and contraceptive effectiveness, it would seem to be important for family planning programs to serve both sexes equally and to be family-centered in underlying philosophy. Programs that focus only on women would seem likely to add to the family problems of all people, especially those of the very poor. The tendency for very poor males and females to live in separate social and psychological worlds, with little communication and sharing of activities, has an adverse effect on all phases of their relationships, both within and outside of marriage.

4. A focus on family planning as a way to improve maternal and child health has general appeal. It also has a great deal of validity, especially from the medical point of view. However, studies show that the majority of poor people are not particularly motivated toward family planning services for health reasons. Thus, while family planning has an important contribution to make to the physical health of mothers and children, perhaps this

should not be its chief rationale or program approach.

5. Studies worldwide indicate that parents generally present economic reasons as the chief motivation for limiting the size of their families. These economic motives are associated with goals that they see as being realistic: more economic security for themselves and their children, and a better chance for their children to have a good education that will lead to steady, well-paying jobs. Thus, family planning would seem to be most effective in reaching poor people when these services are part of a whole complex of economic, educational, medical and vocational programs aimed at alleviating the multiple causes of poverty. A multilateral, rather than a unilateral, program approach is apparently called for, since effective child-spacing and limitation of family size is but one of many interacting causes and effects of a family's escape from poverty. Thus, free, readily accessible, comprehensive family planning services are necessary as one strand in a whole network of remedial programs and services.

6. These family planning and related services are most likely to be effective if they are offered in a positive way that includes an understanding and appreciation of individual situations, attitudes, values, knowledge and beliefs.

Suggested Operating Practices

General principles have been suggested in the foregoing section; now it is appropriate to turn to specific practice suggestions flowing from the summarized research evidence and the derived principles. Of necessity, these will be presented in a highly condensed form. Administrators and practitioners may wish to amplify and change them extensively as a result of their own knowledge and experience.

1. A family planning service would probably benefit from a team approach that includes physicians, nurses, social workers and educators. This does not necessarily imply that a family planning center manned by a multidisciplinary staff is mandatory or even particularly desirable. This team approach can be developed through appropriate communication links between operating agencies that already serve poor people--such as clinics, public health departments, public and private social agencies, religious institutions and the schools. This type of interagency communication and cooperation is difficult, admittedly, but it can be made to work if there is sufficient commitment to the idea and if there is appropriate administrative structuring. One example of such coordination may be found in Mecklenburg County, North Carolina, where the Departments of Public Health, Public Welfare and Education have worked closely together.[27]

2. Since there is such a shortage of professional workers and a high demand for their skills on the one hand, and a need to find jobs for nonprofessionals on the other, family planning programs--like other service programs--might well be staffed, in part, by nonprofessionals. The Planned Parenthood Federation clinics have long demonstrated that volunteers can be effectively used. These volunteers have generally been middle-class women who have made a major contribution to the programs. Along with volunteers of this kind, other volunteers from less advantaged groups as well as paid nonprofessionals might be added to family planning services. For example, some studies [11, 12] and field observations indicate that the community worker, (the so-called indigenous nonprofessional) appropriately trained and experienced, can serve very importantly as an agent for informing people about the existence and usefulness of family planning services. This person, who is apt to have great understanding of the neighborhood and its people, can also serve to remind patients of their appointments, check up on program dropouts and help with problems of transportation and of child-care.

3. Family life and sex education and counseling are an important part of a comprehensive family planning program.

This is a multidisciplinary function, including as it does the physical, social, psychological and economic aspects of individual and family life. There is an acute shortage of trained persons in this field, although individuals from a number of professions have developed considerable expertise and interest in it. These professions include: health education, adult education, public health nursing, social work and home economics (specialists in family living and child development).

Generally, only a small proportion of the members of these professional groups have particularly specialized in the field of family life and sex education. Moreover, their tendency has been to work with middle-class groups. Programs for very poor people would seem to require modifications of the approaches that have been generally used. A recent Children's Bureau publication[28] based on a national workshop sponsored by the Interdepartmental Committee on Children and Youth provides some guidelines for parent education with low-income families. These guidelines, which are drawn from the observation and experience of a number of professional family life educators, emphasize the importance of: working with small groups; the provision of auxiliary counseling services; the use of discussions rather than lectures; reaching out personally to potential members; understanding the life styles and situations of group members; leaving the choice of activities to the group; and a warm, accepting approach by the leader.

In the specific area of sex education, it is important that the group leader be especially sensitive to the life styles and situations of poor people (see pp. 6, 7). Since many leaders are of middle-class orientation, they may need to exercise particular flexibility and understanding to avoid imposing their own point of view on others. Some may feel obligated to take a "moral stand." However, it is well to bear in mind that understanding the behavior of others is not the same as endorsing it. In order to help people find new ways of thinking and behaving one must start with a respect and compassion for them as individuals whose behavior grows out of their life experiences. When this behavior is defeating to the individual and a threat to society, changes are indicated for the individual and often for the society which had a part in shaping the behavior.

The practitioner working with individuals or groups of individuals often cannot personally involve himself in both individual and societal changes. He may need to leave the latter up to other agencies and organizations. But he may be able to work with the individual to find new behavioral patterns that are both helpful to the individual and acceptable to the community. Since behavior grows out of a whole lifetime, it cannot be expected to change quickly. New learnings may emerge gradually. These new learnings are unlikely to persist unless the individual experiences success and a sense that his new life style is more rewarding to him than his old one.

Since individuals and groups of individuals are highly various in their situations and total functioning, it is probable that no one strategy will be effective in bringing about behavior changes. It is also probable that some individuals, for a variety of reasons, cannot or will not change. Clearly, patience and flexibility are called for on the part of the practitioner.

There is a good deal of interest recently in group counseling and educational practices that are aimed at "resocialization"--that is, helping disadvantaged adolescents and adults acquire more socially acceptable and adaptable behavior patterns.[29] This process, too complex to be detailed in this article, includes specific teaching of more viable ways of behaving. Such teaching, however, is not of a didactic kind but might be thought of as being akin to the kindly, firm, consistent and tolerant guidance offered by a good parent.[30, 31]

In these programs it is important to involve males, as well as females. Experiences between the sexes in participating in guided group discussions and group activities should be of significant

aid in helping them build more flexible, trusting, interpersonal relationships. Since it is difficult to alter long-established life styles, such shared group activities would probably be more readily established for younger boys and girls.

The need for programs in family life and sex education aimed at reducing the male-female communication gap is particularly emphasized by Hill and others[22] who found in family planning experiments in Puerto Rico that failures in contraceptive effectiveness were closely associated with the fact that such a gap existed and that programs were addressed only to women.

Imaginative, experimental approaches are called for, especially since the great majority of practitioners report great difficulty in reaching and involving low-income males in family life and sex education programs.

In developing family life and sex education services it would seem wise to find out what programs may already be operating in a community. There may be local members of national organizations[32] who have a specialized competence in this field. Coordination of these activities where they exist would seem to be more practical than establishing new ones, especially in light of the personnel shortages in this field.

Educational materials are available from a number of sources.[31] Moreover, activities are under way in the Welfare Administration to develop appropriate guides to such materials. A major problem has been that existing publications and films on sex and family life education tend to be couched in terms of the middle-class culture, situation, reading level and vocabulary.

4. It appears to be important in many cases for the practitioner (doctor, nurse, social worker or aide) to take the initiative in bringing up the subject of family planning in a person-to-person contact.[27, 34-37] Many disadvantaged people are hesitant to do so, feeling ashamed of their own lack of knowledge, fearing rejection or criticism, lacking communication skills and suffering from cultural taboos about discussing matters relating to sex. Since talking about these matters with a person of the opposite sex may be especially difficult for the disadvantaged, it may be important--at least initially--for women workers to talk with girls and women, and male workers to talk with boys and men. Eventually, cross-sex communication would seem to be indicated in order to help people overcome their problems in this area.

A simple, direct, specific style of speaking with very poor people is likely to be most effective, since the poor are apt to distrust and be confused by an abstract, impersonal approach. It is important, of course, to avoid any indication of pressure or coercion because participation in a family planning program must be a matter of individual decision. However, people need information about family planning and the availability of services so that they can make such a decision. The discussion might most logically be initiated through a question to parents as to whether or not they would like help in spacing their children or in limiting the size of their families.

There is likely to be anxiety and misinformation about contraceptive methods. While the choice of method is determined by the parents, in consultation with the physician, it would seem useful and appropriate for other personnel in contact with the family to give general information about the different kinds of contraceptives that are available. This may be especially necessary since there is an acute shortage of physicians, and since a number of very poor people (often those who need help the most) fail to come to medical centers on their own initiative.

Initiating a discussion about family planning, providing information about possible methods, and giving medical referrals may not be sufficient action to encourage persons who want this aid to actually take steps to get it. Problems of transportation and child-care, fears of losing public assistance grants, embarrassment and patterns of distrust may operate. Empathy, patience, and encouragement on the part of health and welfare

personnel working cooperatively together are called for.[27] This applies to follow-up services as well as to referrals.

5. As suggested earlier, a family planning program cannot stand alone. It must be combined with many other forms of assistance to the family so that parents feel that they and their children actually do have a chance for a better present and future if they actively engage in family planning.

6. A family planning program does not need to be in a specialized clinic structure. From the social, psychological and administrative point of view, it may better be part of a general, comprehensive medical service or even part of a neighborhood health and welfare center. Among the reasons for this suggestion are the need for improvement of the delivery system of the whole complex of services that are required to facilitate the escape from poverty, the importance of a neighborhood program that is easily reached and readily understood, the need for a coordinated approach to all the problems of a family--rather than a fragmentation of the family through a fragmentation of services--and the reduction of personal embarrassment in applying for help. This factor of embarrassment is apt to be particularly relevant for family planning services; approaching a general, nearby neighborhood center is less readily identifiable as a search for help in controlling conception.

This concept of a multipurpose neighborhood service center can be broadened to include a mobile, multiservice unit to reach out to rural areas. In reference to family planning, the plight of isolated families is serious indeed. It is reported that a mobile unit offering comprehensive medical care to the family tends to be much more acceptable and successful than one devoted specifically to family planning.

7. In all of these programs, careful attention must be given to completely equal, integrated, and high quality treatment for whites and nonwhites alike. Negroes have tended to get particularly low-quality medical care in the United States; they have suffered a double discrimination based on racial prejudice and on their higher ratio of poverty.[33] The greater difficulty that Negroes tend to have in limiting family size has been detailed in the first section of this paper. Because of their special need for help in family planning and because of the multiple disadvantages they have suffered in lack of access to high quality medical care, it is particularly important that family planning services be offered in an atmosphere of dignity and respect.[27]

8. Family planning services should be available at hours that are suitable for parents who are faced with problems of child-care and employment. Night clinics, elimination of waiting lines and free access to staff by telephone are among the program needs.

The above suggestions are not meant to imply that family planning services should be offered only in neighborhood centers. For example, medical personnel report that a family planning service directly associated with a hospital's obstetrical service has proved to be eminently successful. One of the reasons is that mothers tend to be particularly interested in family planning immediately following the birth of a baby. While the mother is in the hospital, family planning information and education can be given. Such a service might well be coordinated with services in neighborhood centers.

III. SUGGESTIONS FOR RESEARCH AND STUDY

1. Only a few of the pertinent research issues are sketched here. Further developments in this area are presently going forward in the Division of Research of the Welfare Administration.

According to Bogue,[38] the pressing social research need in the family planning field at present is for a series of experimental programs in service delivery, with a built-in evaluation component. Surveys of family planning knowledge, attitudes and practice have provided generally sufficient information on the needs and desires for service on the part

of the various groups in the population. The question now is, how can these needs and desires be most effectively met? There are many opinions as to what constitutes a good family planning program and what methods are necessary. These opinions--including those presented in this article--need to be translated into experiments and subjected to careful evaluation.

2. Studies are indicated regarding different types of family planning services as they relate to different kinds of communities. For example, what community conditions need to exist in order to make the establishment of a comprehensive family planning service possible? What community conditions are associated with widespread acceptance and use of such services? Are there different models of services that may be particularly well adapted to different communities? How can communities with meager resources of trained personnel develop such resources? Demonstration projects in various localities are being encouraged by the Welfare Administration through funds available from the Bureau of Family Services under the Social Security Act.

3. Research would seem to be indicated concerning the "social-psychological side effects" of family planning. Considerable attention has been paid to the medical aspects but social and psychological factors are of equal importance. For example, what are the effects of small family size on the behavior and roles of women? What will women, who formerly made a life career of motherhood, do with the increased amount of time and energy at their disposal as a result of limiting the size of their families? If they find second careers in the community and labor market, what effect will this have on them, their husbands and their children? (These trends already exist, of course; more extensive use of family planning will merely intensify them.) We know very few of the answers to these questions, especially as they refer to different socioeconomic levels.

4. Other social-psychological side effects that need to be studied include the effect of contraceptive use, or nonuse, on the marriage relationship and the stability of the marriage. Are there differential effects related to the use of different kinds of contraceptives? Are there differential effects associated with different types of child-spacing? What are the effects of contraceptive failure on the marriage relationship?

What are the effects of planned families on children? For example, are there optimal patterns of family size and child-spacing that seem to be highly associated with positive parent-child and sibling relationships as well as with optimal child development?

5. There is widespread concern as to the effects of simple, readily obtainable contraceptives on the premarital behavior of youth. There are also a number of prescriptions as to what is needed to help youth handle this situation. More needs to be known regarding the actual impact of contraception on youth behavior--in reference to both males and females--at different socioeconomic levels. Evaluative studies as to the effects of such proposed remedies as sex and family life education are also in order.

6. Follow-up studies are needed over a period of five years or more in order to ascertain long-range use of family planning services. In these studies, research is indicated concerning: (a) characteristics of those persons who are referred for services but fail to apply for them;* (b) those who attend the clinic but drop out; (c) those who continue to attend. Differences in child-spacing and family size between these three groups should be measured as well as associated differences in social, economic, situational and psychological characteristics. Information should also be sought from both men and women as to the reasons for their participation or non-participation in family planning programs.

** Such a study has been launched recently by Dr. Joseph Beasley of the Tulane University School of Medicine, New Orleans, La., under a research grant from the Children's Bureau, Welfare Administration.*

CONCLUSION

An overview and analysis of selected social and psychological research related to family planning and poverty has been presented here, along with some of the implications for administrative policy, programs and further study. Emphasis has been placed on particular problem areas which would seem to require imaginative, experimental approaches for their solution.

This focus on problem areas may have created the impression that family planning programs are unlikely to be of effective help to low-income persons. Actually, it is reported that a large number of disadvantaged women of childbearing age readily attend family planning clinics when such clinics are of high quality and easily accessible. It is further reported that women who attend these clinics and who obtain effective help are likely to be excellent communicators to other potential patients.

These positive reports and observations are not validated through long-range objective studies. Such observations are tempered by less positive ones, including reports that a sizable proportion--perhaps half--of low-income patients drop out of family planning programs within the first year of clinic attendance.

Since poor people are individuals with their own particular physical, social, economic and psychological characteristics, no one approach to family planning will be acceptable and useful to every person who needs and wants such a service. Moreover, since communities vary in resources, needs and prevalent attitudes, no one approach to family planning programs is likely to be applicable to every community. Variable, flexible, imaginative programs are called for, along with objective evaluation as to the costs and outcomes of a variety of approaches. Fairly simple solutions to the family planning needs of a sizable proportion of low-income persons in a large number of communities may be available, and successful programs are reported to be in operation at present in some parts of the country; more varied and complex services may be needed only for a minority of communities and population groups. Whether or not this is a correct analysis of the situation is not known at present. As already suggested, long-range objective studies are called for to provide answers to this and related questions.

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NOTE

Extending Child Welfare Services

States' Progress

The 1962 welfare amendments to the Social Security Act included four important dimensions in extending and strengthening public child welfare services. The amendments stipulate that these services should be: (1) provided in all political subdivisions of each State by July 1, 1975; (2) available for all children in need of such services; (3) expanded in scope through a new definition of child welfare services; and (4) improved in quality through the provision of services by trained child welfare personnel.

The amendments also require that States make satisfactory advances each year in extending the provision of child welfare services.

The Children's Bureau has been following the progress of each State since the passage of these amendments. It is, of course, easier to measure extension of services in some of the dimensions than in the others. From the figures in the accompanying table it can be seen that substantial gains have been made in coverage of services in political subdivisions, in reaching children in need of services, in increasing child welfare staff, in sending workers to schools of social work for professional training, and in expenditures for child welfare services.

Other aspects of child welfare services, in addition to the four dimensions already outlined, are also important, such as foster care of children outside their own homes, protection to neglected and abused children and services to children with handicaps, such as mental retardation. There have been some gains in these areas, too, but they have been spotty.

In fiscal year 1966, with a steadily increasing number of children in foster care, difficulties in the recruitment of foster family homes continued and there was no proportionate increase in needed staff and funds. There was, however, a trend toward experimentation in the use of foster care for children with special needs, such as the emotionally disturbed and mentally retarded. *Quest for Equality*, a Children's Bureau publication (September 1966), describes the steady progress being made by voluntary child-caring institutions throughout the Nation in achieving compliance with Title VI of the Civil Rights Act of 1964.

Public child welfare agencies continued to face many serious problems in their efforts to extend protective services to neglected and abused children. As a result of the child abuse laws enacted by most States, making mandatory the reporting by physicians and hospitals of suspected child abuse, there was concern about the inadequacy of services available. Only a small number of States have provided appreciable funds for expanding protective services and demands on the public child welfare agency are increasing, particularly in urban areas where some voluntary agencies are tending to withdraw from this area of service, considering this to be the rightful function of the public welfare agency.

States report some increase in preventive services to children in their own home, although all States recognize the need for more effort in this direction. As interpretation of services is given to schools, hospitals, churches and courts, referrals are being made at an early point of trouble when there is often the most hope of effecting positive changes. Too often, however, child welfare services are available only in crisis situations or they are provided too late to be fully effective.

Shortage of qualified staff, as well as the still-limited availability of day care and homemaker services, hamper

	1962	1963	1964	1965
Counties Served	1,762	1,873	1,999	2,114
Increase Over Previous Year	--	111	126	115
Percent of Counties Served	54.8%	58.3%	62.4%	65.9%
Increase Over Previous Year	--	3.5%	4.1%	3.5%
Percent of Child Population in Counties Served	82.3%	84.9%	87.1%	88.6%
Increase Over Previous Year	--	2.6%	2.2%	1.5%
Total Children Served	422,800	457,300	487,500	531,200
Increase Over Previous Year	--	34,500	30,200	43,700
Rate of Children Served per 10,000	56	60	62	67
Increase Over Previous Year	--	4	2	5
Professional Child Welfare Staff	8,724	9,348	10,379	11,429
Increase Over Previous Year	--	624	1,031	1,050
Child Welfare Workers per 10,000 Children in Counties Served	1.0	1.1	1.2	1.3
Increase Over Previous Year	--	.1	.1	.1
Child Welfare Workers on Educational Leave	809	914	1,069	1,018
Increase/Decrease Over Previous Year	--	105	155	-51
Expenditures for Child Welfare Services - Total (in millions)	246	268	313	352
State-Local Expenditures for Child Welfare Services (in millions)	228	242	284	318
Increase Over Previous Year	--	14	42	34

the ability of public child welfare agencies in extending programs to children in their own homes.

The number of adoptions in the United States continues to increase and in 1965 reached 142,000. Of all non-relative adoptions, 69 percent were social agency placements. Public child welfare agencies are expending greater efforts in placing children who are handicapped, older, nonwhite, or of mixed racial background. However, the number of children in need of adoption is increasing so rapidly that agencies are not able to keep pace.

Public child welfare agencies have continued to expand and improve their day care services and 27 States now provide some State funds for these services. A concerted effort has been made in many States to upgrade standards and extend the protection of adequate licensing requirements. Cooperation between Office of Economic Opportunity programs and those of State child welfare agencies has improved, and there is greater involvement of the child welfare agency in planning for the care of children whose parents are receiving job training under Work Experience and Training (Title V) programs.

The increase in the number of homemaker programs in both public and voluntary child welfare agencies has been

dramatic: in May 1966 there were a total of 579 programs, almost double the number in existence two years previously, with public child welfare agencies accounting for the greatest percentage of new programs. All but ten States included some provision for homemaker services in their 1966 child welfare plans.

Cooperative planning and communication between public child welfare and other agencies serving the mentally retarded are now more in evidence. As the needs of this group of children have become more visible, public child welfare agencies have been assuming increased responsibility for extending services, especially homemaker and day care services.

By July 1965, 50 States had made provision for full-time staff development positions at the State level and in December 1965, over 450 full-time personnel were available in State and local public welfare agencies for staff development in both public assistance and child welfare programs. Forty States had overall staff development programs including orientation and in-service training on a continuing basis. Good progress has been made in certain States in training new child welfare staff who hold B.A. degrees. There is widespread interest in examining new ways of utilizing existing staff with different levels of training.

There has been a notable expansion of resources for graduate training of social workers and an increase in the number of applications for social work education. Enrollment in schools of social work for the 1965-66 academic year increased 14 percent over the previous year. In fiscal year 1966, Child Welfare Training grant awards totaled $5 million. However, there is a continuing shortage of child welfare personnel with graduate degrees. In June 1965, only 27 percent of professional employees in public child welfare had completed graduate social work education and the percentage of child welfare workers with full professional education was only 16 percent. Despite the substantial number of persons granted educational leave by public child welfare agencies over the past five years, the number of workers sent on such leave must be greatly increased.

Public child welfare agencies are giving increasing recognition to the needs of children located in metropolitan areas. In these burgeoning urban areas, there is a concentration of needs: large numbers of children in need of care while parents work or train for work; children in deteriorating family situations who need supplementary parental help on a temporary basis; children who are mentally retarded who must be reached by available services; hundreds of children in need of foster care or shelter care while they await adoptive placement.

To facilitate services to children in these urban areas, State child welfare agencies are engaged, as never before, in cooperative efforts with State departments of education, health, mental health, labor and vocational rehabilitation. They are working closely on both State and local levels with Community Action and Head Start programs.

Advisory committees are being used increasingly for a variety of purposes, including: long-range planning, public interpretation, guidance in the development of standards and licensing requirements, and sponsorship of conferences and workshops for professional and citizen leaders. Within these advisory groups are representatives of other community organizations also interested in child welfare, including: the Junior League, National Association of Social Workers, American Legion, League of Women Voters, Parent-Teacher Associations, and the AFL-CIO.

There are indications that unpaid volunteers in public child welfare agencies are being more widely used to assist in the provision of direct services. Public information and interpretation of child welfare needs and the purposes served by child welfare programs are being strengthened. Public child welfare agencies are giving increasing leadership in community planning councils and are taking a more active part in surveys of needs as well as in developing patterns for collaboration among agencies for coordinated delivery of services. In a number of cities

this has led to cooperative agreements between the public child welfare agency and public housing project officials for the provision of day care and a range of other services.

Staff of public child welfare agencies in many States are already carrying out a wide variety of community planning tasks on State, local and regional levels. This trend is one which all States will want to intensify with greater interdisciplinary collaboration and increased interagency coordination to achieve the objective of extending child welfare services.

Much has been accomplished since the 1962 welfare amendments. State agencies are at the same time aware that much remains to be done and that they must continually push forward in developing child welfare services, an area of vital concern to the welfare of children and their families.

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Program and Operating Statistics

Public Assistance in December 1966

The continued effect of seasonal influences on employment conditions was reflected in the increases of 97,000 (2.1 percent) in the number of people receiving aid to families with dependent children and of 51,000 (8.4 percent) in the number who received general assistance. For aid to families with dependent children, 37,000 of the increase in number of recipients occurred in the unemployed-parent segment. Contributing most of this part of the total increase were California (20,000), New York (6,000), Washington (4,000), and Pennsylvania (3,000). These four States combined also accounted for more than half (33,000) of the increase of 60,000 among those found eligible for aid to families with dependent children for reasons other than the unemployment of a parent.

In old-age assistance and aid to the blind the number of recipients decreased 5,500 and less than 100, respectively, and in aid to the permanently and totally disabled the number rose by 2,800. Medical assistance for the aged showed an increase of 800 in individuals for whom payments were made. In States reporting this count for medical assistance under title XIX there was a decrease of 55,000 or 6.2 percent in the number of persons on whose behalf payments were made during the month.

The recent provision of initial social security cash benefits to uninsured individuals aged 72 and over, effective beginning with October, continued in December to be a factor in the discontinuance of money payments to persons receiving public assistance. In October-December 1966, an estimated 20,000 discontinuances of money payments were related to the receipt of such benefits; about 15,000 of these money payment terminations were in old-age assistance.

Total expenditures for assistance were $577.1 million in December--$5.9 million more than in November. Total money payments rose $8.0 million, largely because of the increases of $4.5 million in aid to families with dependent children and $1.7 million in general assistance. Other increases in money payments were $904,000 in old-age assistance, $850,000 in aid to the permanently and totally disabled, and $60,000 in aid to the blind. Total medical vendor payments decreased $2.1 million, reflecting mainly decreases of $940,000 in medical assistance and an estimated $1,000,000 in general assistance.

New Mexico initiated a program of medical assistance under title XIX in December, increasing to 28 the number of jurisdictions administering medical assistance under this title.

Table 1. Amount of public assistance payments in the United States, by month, December 1965-December 1966[1]

Year and month	Total	Money payments 2/ (In thousands)							Medical vendor payments 3/ (In thousands)					
		Total	Federally aided programs					General assistance 5/	Total	Federally aided programs				General assistance 5/
			Total	Old-age assistance 4/	Aid to the blind 4/	Aid to the permanently and totally disabled 4/	Aid to families with dependent children			Total	Medical assistance 6/	Medical assistance for the aged 4/	Other	
	Amount of assistance													
1965														
December....	$470,283	$341,391	$319,985	$131,674	$6,922	$37,035	$144,355	$21,407	$128,892	$119,369	---	$52,863	$66,505	$9,523
1966														
January.....	474,298	346,412	324,711	133,005	6,994	37,819	146,892	21,701	127,886	119,785	$20,450	44,956	54,379	8,101
February....	480,280	348,896	326,841	132,594	6,965	38,105	149,176	22,056	131,384	122,898	7/ 19,635	47,593	55,670	8,486
March.....	501,478	352,518	329,823	132,158	7,073	38,632	151,961	22,695	148,960	138,032	7/ 44,549	41,399	52,083	10,928
April.....	498,076	350,833	329,389	132,591	7,033	39,054	150,711	21,443	147,244	136,225	7/ 46,718	37,458	52,049	11,019
May.....	517,565	351,379	330,698	133,382	7,062	39,628	150,626	20,681	166,186	155,230	7/ 81,353	28,183	45,693	10,956
June.....	530,313	352,081	331,320	133,819	7,095	39,996	150,409	20,761	178,232	167,920	7/ 94,410	28,118	45,392	10,312
July.....	511,843	357,767	337,084	136,174	7,173	40,811	152,925	20,683	154,076	144,233	7/101,459	17,762	25,012	9,843
August.....	530,518	363,888	341,897	137,945	7,219	41,576	155,157	21,991	166,630	157,695	7/112,489	18,802	26,404	8,935
September...	529,450	373,355	350,705	140,297	7,280	42,162	161,006	22,650	156,095	148,057	7/115,545	11,616	20,896	8,038
October.....	537,857	374,092	351,519	140,486	7,244	42,524	161,265	22,573	163,765	155,077	7/128,911	5,823	20,343	8,688
November....	571,157	377,953	355,448	140,180	7,208	43,073	164,987	22,505	193,204	185,405	7/160,124	5,245	20,036	7,799
December....	577,071	385,957	361,771	141,084	7,268	43,920	169,499	24,186	191,113	184,325	7/159,184	5,087	20,054	6,788
	Percentage change from preceding month													
1965														
December....	+1.1	+1.1	+0.8	-1.6	+1.6	+1.0	+3.1	+5.1	+0.9	+1.4	---	+1.4	+1.4	-4.5
1966														
January.....	+.9	+1.5	+1.5	+1.0	+1.0	+2.1	+1.8	+1.4	-.8	+.3	---	-15.0	-18.2	-14.9
February....	+1.3	+.7	+.7	-.3	-.4	+.8	+1.6	+1.6	+2.7	+2.6	-4.0	+5.9	+2.4	+4.8
March.....	+4.4	+1.0	+.9	-.3	+1.6	+1.4	+1.9	+2.9	+13.4	+12.3	+126.9	-13.0	-6.4	+28.8
April.....	-.7	-.5	-.1	+.3	+.6	+1.1	-.8	-5.5	-1.2	-1.3	+4.9	-9.5	-.1	+.8
May.....	+3.9	+.2	+.4	+.6	+.4	+1.5	-.1	-3.6	+12.9	+14.0	+74.1	-24.8	-12.2	-.6
June.....	+2.5	+.2	+.2	+.3	+.5	+.9	-.1	+.4	+7.2	+8.2	+16.0	-.2	-.6	-5.9
July.....	-3.5	+1.6	+1.7	+1.8	+1.1	+2.0	+1.7	-.4	-13.6	-14.1	+7.5	-36.8	-44.9	-4.5
August.....	+3.6	+1.7	+1.4	+1.3	+.6	+1.9	+1.5	+6.3	+8.1	+9.3	+10.9	+5.9	+5.6	-9.2
September...	-.2	+2.6	+2.6	+1.7	+.8	+1.4	+3.8	+3.0	-6.3	-6.1	+2.7	-38.2	-20.9	-10.0
October.....	+1.6	+.2	+.2	+.2	-.5	+.9	+.2	-.3	+4.9	+4.7	+11.6	-49.9	-2.6	+8.1
November....	+6.2	+1.0	+1.1	-.2	-.5	+1.3	+2.3	+1.7	+18.0	+19.6	+24.2	-9.9	-1.5	-10.2
December....	+1.0	+2.1	+1.8	+.6	+.8	+2.0	+2.7	+7.5	-1.1	-.6	-.6	-3.0	+.1	-13.0
	Percentage change from same month of preceding year													
1966														
December....	+22.7	+13.1	+13.1	+7.1	+5.0	+18.6	+17.4	+13.0	+48.3	+54.4	---	-90.4	-69.8	-26.7

1/ All data subject to revision.
2/ Includes nonmedical vendor payments.
3/ Amounts represent primarily bills paid during the month and therefore are subject to fluctuations unrelated to provision of medical services.
4/ Represents data for recipients of the specified types of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged.
5/ Partly estimated. Does not include Idaho, Indiana, and Nebraska for which data not available.
6/ Program initiated January 1966 under Public Law 89-97.
7/ Data incomplete. See table 10 for States reporting for most recent month.

7/ Data incomplete. See table 10 for States reporting for most recent month.

Table 2. Number of recipients of public assistance money payments in the United States, by month, December 1965-December 1966[1]

Year and month	Federally aided programs								General assistance 2/	
	Total	Adult programs				Aid to families with dependent children				
		Total	Old-age assistance 3/	Aid to the blind 3/	Aid to the permanently and totally disabled 3/	Families	Total recipients 4/	Children	Cases	Recipients
	Number of recipients (In thousands)									
1965										
December	7,125	2,729	2,087	85.1	557	1,054	4,396	3,316	310	677
1966										
January	7,154	2,715	2,074	84.8	556	1,063	4,439	3,346	319	714
February	7,202	2,715	2,071	84.7	560	1,073	4,487	3,382	319	714
March	7,246	2,722	2,074	84.7	563	1,082	4,524	3,409	321	712
April	7,258	2,731	2,080	84.5	566	1,086	4,527	3,418	302	647
May	7,238	2,733	2,078	84.6	570	1,084	4,505	3,405	290	609
June	7,206	2,734	2,076	84.5	573	1,079	4,472	3,382	286	592
July	7,189	2,732	2,078	84.4	570	1,076	4,457	3,371	279	574
August	7,217	2,737	2,078	84.4	574	1,084	4,480	3,390	286	597
September	7,256	2,748	2,084	84.4	580	1,091	4,508	3,414	286	597
October	7,284	2,756	2,089	84.1	583	1,097	4,528	3,428	287	596
November	7,316	2,748	2,079	83.8	585	1,108	4,568	3,460	288	611
December	7,410	2,745	2,073	83.7	588	1,127	4,666	3,526	302	663
	Percentage change from preceding month									
1965										
December	+1.5	+0.3	(5/)	+0.1	+1.4	+1.9	+2.2	+2.1	+3.4	+5.6
1966										
January	+.4	-.5	-.7	-.4	(6/)	+.8	+1.0	+.9	+2.7	+5.6
February	+.7	(5/)	-.1	-.1	+.6	+1.0	+1.1	+1.1	-.1	-.1
March	+.6	+.3	+.2	(6/)	+.6	+.8	+.8	+.8	+.8	-.3
April	+.2	+.3	+.3	-.2	+.6	+.4	+.1	+.3	-5.9	-8.9
May	-.3	+.1	-.1	+.1	+.7	-.2	-.5	-.4	-3.9	-6.1
June	-.4	(5/)	-.1	-.1	+.5	-.4	-.7	-.7	-1.6	-2.9
July	-.2	-.1	+.1	-.2	-.7	-.2	-.3	-.3	-2.3	-3.1
August	+.4	+.2	(5/)	(5/)	+.8	+.7	+.5	+.6	+2.2	+3.8
September	+.5	+.4	+.2	(6/)	+.9	+.6	+.6	+.7	+.1	(5/)
October	+.4	+.3	+.3	-.3	+.5	+.5	+.4	+.4	+.3	-.2
November	+.4	-.3	-.5	-.4	+.3	+1.1	+.9	+1.0	+1.2	+2.6
December	+1.3	-.1	-.3	-.1	+.5	+1.7	+2.1	+1.9	+4.8	+8.4
	Percentage change from same month of preceding year									
1966										
December	+4.0	+.6	-.7	-1.6	+5.6	+6.9	+6.1	+6.3	-2.7	-2.1

1/ All data subject to revision.
2/ Partly estimated. Does not include Idaho, Indiana, and Nebraska for which data not available.
3/ Represents data for recipients of the specified types of assistance under separate State programs, and under State programs for the aged, blind, or disabled or for such aid and medical assistance for the aged.
4/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
5/ Increase of less than 0.05 percent.
6/ Decrease of less than 0.05 percent.

Table 3. Number of persons on whose behalf payments were made to medical vendors under programs of medical assistance and medical assistance for the aged, by month, December 1965-December 1966[1]

Year and month	Medical assistance					Medical assistance for the aged		
	States with plans in operation 2/			Persons on whose behalf payments were made 3/		States with plans in operation	Persons on whose behalf payments were made 3/	
	Total	Reporting both number of persons aided and payments		Number	Percentage change from preceding month		Number	Percentage change from preceding month
		Number	Percent of reported payments in such States 4/					
1965								
December....	---	---	---	---	---	47	280,000	-0.2
1966								
January.....	7	6	99.2	330,000	---	40	251,000	-10.4
February....	7	6	100.0	321,000	-2.8	40	255,000	+1.9
March.....	8	6	54.2	389,000	+21.0	39	220,000	-14.0
April.....	8	6	48.3	369,000	-5.0	39	218,000	-.9
May.....	9	7	52.8	598,000	+61.9	38	190,000	-12.7
June.....	9	7	49.6	628,000	+5.0	38	195,000	+2.8
July.....	24	12	49.4	678,000	-8.1	5/ 23	100,000	-49.0
August.....	24	12	49.7	715,000	+5.4	5/ 25	97,100	-2.6
September...	25	13	55.3	710,000	6/ -3.5	5/ 24	66,300	-31.7
October.....	26	13	52.2	787,000	+10.8	5/ 23	51,100	-23.0
November....	27	13	54.3	893,000	+13.5	5/ 22	47,600	-6.9
December....	28	13	56.1	838,000	-6.2	5/ 21	48,400	+1.7

1/ States operating medical assistance programs under title XIX of the Social Security Act do not make payments to vendors under any other federally aided public assistance program. Most States not operating medical assistance programs make payments to medical vendors under the program of medical assistance for the aged and also under the other federally aided public assistance programs and general assistance. Medical assistance programs were authorized under the Social Security Amendments of 1965, effective January 1, 1966; programs of medical assistance for the aged were authorized under the Social Security Amendments of 1960, effective October 1, 1960. All data subject to revision.

2/ Includes some States for which action to approve plan taken after State initiated operations under the plan.

3/ Number includes persons in all States reporting for the month. Data represent primarily counts of persons for whom bills were paid during the month and therefore are subject to fluctuations unrelated to provision of medical services.

4/ No recipients or payments reported by Puerto Rico for February to date, or by Virgin Islands for July to date.

5/ Data include payments for care provided prior to specified date under programs discontinued prior to that month.

6/ Based on data for States reporting comparable data for both months.

Table 4. Old-age assistance: Recipients and payments to recipients, by State, December 1966[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	November 1966 in--		December 1965 in--	
				Number	Amount	Number	Amount
Total 2/....	2,073,000	$141,084,000	$68.05	-0.3	+0.6	-0.7	+7.1
Ala.....	113,000	6,839,000	60.80	(3/)	-.2	+1.0	+10.2
Alaska 4/.....	1,400	96,800	70.80	0	+.5	-.5	-.5
Ariz.....	12,900	733,000	56.65	-.6	-.5	-1.0	-3.2
Ark. 4/.....	62,700	3,784,000	60.30	+.5	+.4	+4.5	+26.0
Calif.....	285,000	29,571,000	103.65	+.3	+2.9	+3.1	+13.0
Colo. 2/.....	41,400	3,433,000	82.85	-.2	+1.0	-3.1	+1.6
Conn.....	5,900	418,000	71.05	+1.6	+4.0	+2.0	+13.2
Del.....	1,700	106,000	63.55	-.2	+.3	+14.4	+39.9
D. C.....	2,200	140,000	63.00	-1.1	-.3	-4.0	-4.3
Fla. 4/.....	78,900	3,878,000	49.15	+.2	+.4	+7.2	+1.3
Ga. 4/.....	94,000	4,478,000	47.65	+.1	-.1	+1.5	+2.9
Guam 5/.....	180	6,600	36.20	---	---	---	---
Hawaii 4/.....	1,600	126,000	78.15	+1.5	+4.5	+22.2	+28.0
Idaho.....	3,900	247,000	63.00	-.3	-.6	+.5	+3.1
Ill. 4/.....	39,800	2,547,000	63.95	-1.5	-.9	-20.4	+.7
Ind.....	19,000	944,000	49.65	-1.4	-.7	-4.8	-2.5
Iowa.....	24,500	1,379,000	56.35	-.7	-.4	-4.8	-7.9
Kans. 4/.....	18,000	1,449,000	80.75	-.8	-.1	-7.9	+1.3
Ky. 4/.....	59,400	3,331,000	56.10	+.4	+.1	+1.7	+15.6
La.....	124,000	9,174,000	73.80	+.2	+.1	-4.3	+7.2
Maine 4/.....	10,000	548,000	55.05	+1.0	+.5	-7.8	-3.7
Md. 4/.....	8,100	459,000	56.35	-2.1	-.8	+2.6	+3.1
Mass.....	50,700	4,008,000	79.15	-4.1	-1.8	+3.2	+9.2
Mich.....	39,700	2,882,000	72.55	(6/)	+.4	-10.9	-17.3
Minn.....	28,800	1,632,000	56.75	-4.9	-1.2	-.5	-2.8
Miss.....	74,200	2,897,000	39.05	-.2	-.3	+1.5	+1.2
Mo.....	90,800	6,176,000	68.00	-.3	-.2	-3.1	+6.0
Mont.....	4,100	261,000	63.85	+.1	+.2	-1.5	-2.5
Nebr. 4/.....	11,000	519,000	47.10	-.7	+.6	+20.2	+8.4
Nev.....	2,400	183,000	75.55	+.9	+1.4	+3.5	+12.5
N. H.....	4,200	421,000	99.75	(3/)	+.3	-1.1	+15.0
N. J.....	13,600	946,000	69.40	+.3	+.5	+.1	+3.0
N. Mex. 4/.....	9,400	542,000	57.90	-3.3	-.5	-6.6	-5.8
N. Y. 4/.....	67,100	5,510,000	82.10	+.6	+2.8	+17.4	+27.9
N. C.....	39,800	2,287,000	57.45	-.2	(6/)	-6.0	+.1
N. Dak. 4/.....	4,400	335,000	75.20	-.5	+.3	-4.5	+4.0
Ohio.....	74,000	5,857,000	79.15	-.3	-.2	-2.4	+6.2
Okla. 4/.....	80,800	6,111,000	75.60	-.1	-.3	-1.5	-.2
Oreg.....	11,300	564,000	49.80	-.8	-1.0	+20.8	+1.2
Pa.....	44,000	3,278,000	74.50	-.2	(3/)	+.4	+8.4
P. R. 4/.....	25,800	223,000	8.65	-.8	-1.0	-9.7	-9.3
R. I. 4/.....	4,900	286,000	58.15	-1.6	+9.2	-10.6	-35.2
S. C.....	22,900	949,000	41.40	-1.8	-1.5	-6.7	-2.9
S. Dak.....	5,500	335,000	61.10	-.3	+.4	-14.6	-2.7
Tenn.....	45,800	2,473,000	54.00	+.6	+.1	+2.4	+18.3
Tex.....	229,000	14,130,000	61.70	+.1	+.2	(3/)	+7.9
Utah.....	4,700	252,000	53.15	-.4	+.2	+6.2	-3.5
Vt. 4/.....	4,200	269,000	63.60	-5.6	+.1	-17.4	+10.0
V. I.....	410	15,500	37.75	0	+.2	-6.8	-5.6
Va.....	11,200	589,000	52.50	-.3	-.2	-6.2	-3.3
Wash.....	27,100	1,698,000	62.60	-.5	-.3	-6.7	-4.3
W. Va.....	12,900	585,000	45.20	-2.7	-1.4	-6.4	+5.5
Wis.....	18,200	1,025,000	56.25	+2.0	-.6	-25.5	+26.1
Wyo.....	2,300	159,000	69.65	-.4	-.4	-2.1	-2.9

1/ All data subject to revision. 2/ Includes 3,800 recipients aged 60-64 in Colorado and payments of $339,000 to these recipients. Such payments were made without Federal participation. 3/ Decrease of less than 0.05 percent. 4/ Represents aid to the aged under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged. 5/ Data for October; November and December data not received. 6/ Increase of less than 0.05 percent.

5/ Data include payments for care provided prior to specified date under programs discontinued prior to that month.
6/ Based on data for States reporting comparable data for both months.

Table 5. Aid to the blind: Recipients and payments to recipients, by State, December 1966[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	November 1966 in--		December 1965 in--	
				Number	Amount	Number	Amount
Total 2/ 3/....	83,700	$7,268,000	$86.85	-0.1	+0.8	-1.6	+5.0
Ala.....	1,800	127,000	69.90	-.2	+1.5	-3.1	+2.2
Alaska 4/.....	100	8,600	83.15	+1.0	+1.2	-6.4	-2.3
Ariz.....	730	51,500	70.60	-.4	-1.0	-8.9	-10.3
Ark. 4/.....	1,900	136,000	71.30	0	+.1	-1.6	+17.6
Calif. 2/.....	12,500	1,660,000	132.65	+.3	+1.6	+.8	+8.3
Colo.....	230	16,500	72.30	-.9	-2.1	-3.8	-1.9
Conn.....	270	21,300	78.45	-2.2	+3.0	-3.6	+12.9
Del.....	320	26,800	82.40	-2.1	+.2	-.3	+4.2
D. C.....	200	15,200	75.95	-1.5	+1.0	+3.1	+5.2
Fla. 4/.....	2,600	163,000	62.85	(5/)	+.3	+1.1	+2.9
Ga. 4/.....	3,200	182,000	57.50	-.1	(6/)	-.5	+2.7
Guam 7/.....	6	180	(8/)	---	---	---	---
Hawaii 4/.....	66	6,100	91.80	(8/)	(8/)	(8/)	(8/)
Idaho.....	120	8,600	73.20	-1.7	+1.3	-3.3	+3.7
Ill. 4/.....	2,000	149,000	75.80	-1.6	-.5	-12.7	-1.9
Ind.....	1,600	101,000	64.75	-1.0	-.9	-5.3	-4.4
Iowa.....	1,100	98,000	92.85	+.7	-.4	-2.4	-2.8
Kans. 4/.....	420	37,200	88.85	-1.2	-.4	-9.1	-1.9
Ky. 4/.....	2,500	175,000	70.35	+.4	+.3	+.2	+11.6
La.....	2,500	193,000	76.00	+.3	-.8	-5.6	-7.5
Maine 4/.....	230	17,000	74.85	+3.2	+4.9	-14.7	-13.2
Md. 4/.....	340	24,900	72.70	-2.0	-2.5	-5.8	(6/)
Mass.....	2,300	281,000	123.00	+.8	+11.9	+2.6	-5.0
Mich.....	1,500	122,000	82.20	+.7	+1.9	-9.3	-9.3
Minn.....	870	64,300	73.65	-1.9	-.8	-11.9	-9.8
Miss.....	2,500	113,000	46.10	(5/)	-.1	-2.7	-2.2
Mo. 2/.....	4,100	328,000	80.00	-.2	-.2	-4.9	-4.9
Mont.....	200	14,800	74.55	-5.3	-5.5	-11.6	-9.8
Nebr. 4/.....	480	30,300	63.75	-.4	-.6	+7.0	-4.8
Nev.....	160	17,100	103.75	+1.9	+7.9	+2.5	+9.4
N. H.....	240	26,200	109.60	-.4	+.3	-2.8	+15.8
N. J.....	890	74,900	84.55	-.3	+1.9	-.8	+3.8
N. Mex. 4/.....	340	25,100	72.60	-.6	+.9	-1.4	-2.5
N. Y. 4/.....	3,100	307,000	99.65	-.7	-.9	-2.2	+11.6
N. C.....	4,700	333,000	71.30	(5/)	+.1	-3.5	+4.0
N. Dak. 4/.....	80	6,700	83.25	(8/)	(8/)	(8/)	(8/)
Ohio.....	3,000	234,000	77.45	+.3	+.5	-2.3	+.6
Okla. 4/.....	1,600	164,000	105.45	-.2	-.6	-4.0	-.9
Oreg.....	480	41,200	86.80	0	-4.0	-.2	+1.1
Pa. 3/.....	10,000	1,083,000	108.40	+.2	+.5	+12.0	+20.5
P. R. 4/.....	1,200	10,200	8.80	-.9	-1.3	-11.7	-10.2
R. I. 4/.....	110	8,000	72.55	+.9	+3.5	+2.8	-4.7
S. C.....	1,900	105,000	55.65	-.6	-.7	+.4	+3.4
S. Dak.....	110	8,900	79.90	0	-.2	0	+18.5
Tenn.....	1,800	123,000	66.60	+.3	+.1	-9.9	+5.0
Tex.....	4,300	314,000	73.65	-.1	+.1	-5.0	+1.0
Utah.....	150	8,700	59.05	-.7	+7.2	-8.6	-6.2
Vt. 4/.....	110	7,600	72.15	0	+1.0	-14.5	+.8
V. I.....	10	400	(8/)	(8/)	(8/)	(8/)	(8/)
Va.....	1,100	76,100	69.15	+.7	+1.5	-2.5	+8.8
Wash.....	530	39,500	74.30	-1.1	-1.3	-11.9	-13.1
W. Va.....	720	33,400	46.45	-1.8	-1.0	-5.8	+2.3
Wis.....	630	45,800	73.10	-1.7	+.6	-14.8	+18.1
Wyo.....	50	3,600	72.50	(8/)	(8/)	(8/)	(8/)

1/ All data subject to revision. 2/ Data include recipients of payments made without Federal participation and payments to these recipients as follows: California, $14,500 to 86 recipients and Missouri, $53,200 to 660 recipients. 3/ Does not include $577,000 to an estimated 7,800 recipients under State blind pension program in Pennsylvania administered under State law without Federal participation. 4/ Represents aid to the blind under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 5/ Increase of less than 0.05 percent. 6/ Decrease of less than 0.05 percent. 7/ Data for October; November and December data not received. 8/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.

Table 6. Aid to the permanently and totally disabled: Recipients and payments to recipients, by State, December 1966[1]

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	November 1966 in--		December 1965 in--	
				Number	Amount	Number	Amount
Total.....	588,000	$43,920,000	$74.75	+0.5	+2.0	+5.6	+18.6
Ala.....	15,100	681,000	45.10	+.1	+.2	+1.9	+9.6
Alaska 2/.....	320	23,600	74.35	+2.9	+3.1	+33.2	+40.2
Ariz.....	4,800	317,000	66.10	+1.7	+1.5	+19.8	+18.2
Ark. 2/.....	10,500	679,000	64.65	+.9	+.8	+8.6	+83.0
Calif.....	97,700	11,022,000	112.85	+2.2	+5.0	+21.1	+33.4
Colo.....	6,700	430,000	64.05	+.8	+1.3	+5.5	+7.6
Conn.....	5,700	464,000	80.85	-5.4	+.9	-32.9	+19.2
Del.....	660	59,200	89.05	+3.1	+3.2	+36.0	+63.3
D. C.....	3,500	278,000	78.75	-2.2	+1.4	+6.8	+12.0
Fla. 2/.....	20,500	1,222,000	59.60	+.5	+.8	+14.4	+16.9
Ga. 2/.....	27,800	1,549,000	55.80	+.1	(3/)	+1.0	+3.2
Guam 4/.....	47	1,600	(5/)	---	---	---	---
Hawaii 2/.....	1,300	137,000	106.10	+2.4	+7.0	+24.0	+46.3
Idaho.....	2,700	170,000	63.60	-.4	+1.2	-14.6	+9.0
Ill. 2/.....	29,900	2,320,000	77.50	+.7	+1.7	+1.1	+9.1
Ind.....	2,000	99,600	50.30	0	+.2	+21.4	+17.7
Iowa.....	1,700	110,000	64.40	+1.9	+1.5	+21.2	-9.0
Kans. 2/.....	5,300	555,000	105.20	+.8	+1.3	+6.0	+15.1
Ky. 2/.....	12,900	896,000	69.55	+1.6	+1.5	+9.2	+20.8
La.....	21,400	1,111,000	51.85	+1.0	+.8	+9.1	+6.7
Maine 2/.....	2,300	162,000	71.60	+1.1	+.9	0	+1.2
Md. 2/.....	9,000	653,000	72.30	+1.7	+1.8	+20.1	+24.3
Mass.....	12,900	1,109,000	85.95	-.8	+1.2	+4.7	+24.0
Mich.....	15,200	1,265,000	83.05	-.2	+1.3	+12.7	+7.2
Minn.....	6,400	454,000	70.50	+2.3	+2.8	+50.7	+58.5
Miss.....	21,000	952,000	45.25	-.1	-.2	+7.3	+6.0
Mo.....	16,000	1,169,000	72.85	+.7	+.7	+3.0	+10.1
Mont.....	1,500	104,000	69.80	-1.9	+.2	-9.1	+2.8
Nebr. 2/.....	3,000	181,000	59.95	+1.0	+2.2	+20.4	+19.7
N. H.....	680	60,600	89.70	0	-.2	+6.5	+13.6
N. J.....	8,900	719,000	81.15	+.3	+1.0	+3.7	+9.5
N. Mex. 2/.....	4,400	308,000	70.40	+.3	+2.2	+9.5	+10.4
N. Y. 2/.....	35,400	3,324,000	93.85	+1.6	+2.2	-1.9	+21.4
N. C.....	22,600	1,437,000	63.55	(6/)	+.5	+1.9	+5.4
N. Dak. 2/.....	1,700	135,000	80.45	+1.0	+1.7	+9.1	+17.1
Ohio.....	20,800	1,510,000	72.50	+.7	+.5	+6.1	+14.0
Okla. 2/.....	17,700	1,694,000	95.60	+.6	+.4	+15.8	+21.0
Oreg.....	5,200	385,000	74.80	-.9	-1.3	-35.4	-7.0
Pa.....	22,400	1,720,000	76.70	+1.4	+1.1	+14.1	+21.5
P. R. 2/.....	17,500	152,000	8.65	-7.0	-8.0	+13.3	-13.4
R. I. 2/.....	3,000	229,000	77.15	+.6	+2.5	+2.1	+2.7
S. C.....	9,300	446,000	47.95	+.6	+.6	+1.4	+7.3
S. Dak.....	1,200	78,500	63.20	+1.4	+.9	+7.7	+15.1
Tenn.....	15,300	994,000	64.90	+1.3	+1.2	+8.7	+27.7
Tex.....	11,000	670,000	60.65	+.8	+1.0	+9.3	+16.5
Utah.....	3,300	190,000	56.95	+.5	+2.5	-31.1	-7.6
Vt. 2/.....	1,200	91,100	75.60	+1.3	+3.0	-9.1	+13.3
V. I.....	44	1,800	(5/)	(5/)	(5/)	(5/)	(5/)
Va.....	6,800	422,000	62.15	+.5	(6/)	+2.8	+6.8
Wash.....	10,100	611,000	60.40	-4.9	-1.4	-17.5	+7.5
W. Va.....	5,900	254,000	43.35	-1.2	-.6	+1.5	+8.5
Wis.....	4,400	261,000	59.05	0	+.9	-24.9	+8.9
Wyo.....	760	53,800	71.15	+1.6	+2.2	+6.6	+7.7

1/ All data subject to revision. 2/ Represents aid to the permanently and totally disabled under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ Decrease of less than 0.05 percent. 4/ Data for October; November and December data not received. 5/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 6/ Increase of less than 0.05 percent.

Table 7. Aid to families with dependent children: Recipients and payment to recipients, by State, December 1966[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		November 1966 in--		December 1965 in--	
		Total 2/	Children	Total amount	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 3/....	1,127,000	4,666,000	3,526,000	$169,499,000	$150.40	$36.35	+2.1	+2.7	+6.1	+17.4
Ala.....	17,200	71,000	56,600	897,000	52.30	12.65	+1.0	+1.1	+.4	+7.4
Alaska.....	1,300	4,900	3,800	172,000	131.05	35.10	-.3	-.9	+5.4	+5.6
Ariz. 3/.....	9,800	42,300	32,300	1,190,000	120.85	28.15	+.1	+.1	+5.2	+5.5
Ark.....	8,000	33,500	25,400	655,000	81.50	19.55	+1.7	+2.0	+8.4	+37.9
Calif 3/.....	173,000	709,000	521,000	31,278,000	181.00	44.15	+4.8	+5.0	+18.1	+20.5
Colo. 3/.....	13,000	51,500	39,500	1,915,000	146.80	37.15	+2.1	+2.3	+13.8	+19.0
Conn. 3/.....	12,900	51,100	38,400	2,480,000	192.40	48.55	+.8	+.1	-.6	+8.8
Del. 3/.....	3,100	13,300	10,200	406,000	132.05	30.45	+4.0	+3.8	+12.6	+19.5
D. C.....	4,900	23,000	18,600	769,000	157.80	33.45	+.7	+1.5	+1.7	+2.2
Fla.....	35,100	138,000	110,000	2,109,000	60.15	15.30	+1.2	+.8	+26.3	+27.6
Ga.....	22,500	89,600	69,300	2,116,000	94.20	23.60	+2.1	+2.3	+15.8	+23.3
Guam 4/.....	150	800	680	13,200	86.95	16.50	---	---	---	---
Hawaii 3/.....	3,800	16,500	12,200	693,000	182.35	41.95	+1.9	+1.0	+11.9	+19.3
Idaho.....	2,700	10,400	7,600	450,000	165.90	43.10	+1.1	+1.4	+6.1	+16.8
Ill. 3/.....	52,600	247,000	194,000	10,372,000	197.10	41.95	+.1	+1.2	-2.0	+4.0
Ind.....	11,100	46,400	35,200	1,269,000	114.05	27.35	(5/)	-.1	-1.2	+1.5
Iowa.....	11,100	43,700	31,900	1,711,000	154.80	39.20	+.3	-.3	-1.1	-.2
Kans. 3/.....	8,400	35,000	27,300	1,507,000	179.25	43.05	+.9	-.2	-.3	+20.2
Ky.....	22,100	86,300	62,700	2,411,000	109.35	27.95	+2.1	+2.1	+6.2	+31.9
La.....	25,200	111,000	85,500	2,659,000	105.70	23.90	+2.0	+2.1	+4.3	+9.2
Maine.....	5,300	19,900	14,600	591,000	111.35	29.70	+2.0	+1.6	+8.5	+9.2
Md. 3/.....	23,000	94,500	73,300	3,417,000	148.85	36.15	+2.2	+2.3	+5.6	+12.1
Mass. 3/.....	29,100	110,000	83,000	5,758,000	197.65	52.40	+1.6	-.3	+11.1	+30.1
Mich. 3/.....	37,500	6/ 153,000	6/ 115,000	6,221,000	166.05	---	---	+.7	---	+16.8
Minn.....	14,600	53,800	41,800	2,537,000	174.30	47.20	+.8	-.2	+2.9	+10.1
Miss.....	21,200	87,400	70,500	809,000	38.15	9.25	+.7	+.8	+5.3	+19.3
Mo.....	25,900	108,000	82,900	2,690,000	103.75	25.00	+.3	+.3	(7/)	+5.0
Mont.....	2,200	8,600	6,600	315,000	143.05	36.65	+2.4	+1.7	+9.6	+10.7
Nebr. 3/.....	4,900	19,800	15,200	580,000	118.15	29.35	+1.3	+3.6	+10.9	+13.4
Nev.....	1,500	6,400	5,100	200,000	129.25	31.15	+4.8	+4.8	+15.4	+21.3
N. H.....	1,300	5,300	4,000	216,000	169.30	40.85	+2.3	+4.0	+13.1	+22.1
N. J.....	30,300	121,000	92,500	6,131,000	202.65	50.50	+1.3	+1.5	+9.3	+12.7
N. Mex.....	7,900	32,700	24,900	977,000	123.40	29.90	+1.4	+1.6	+8.2	+9.5
N. Y. 3/.....	153,000	630,000	465,000	34,689,000	226.85	55.10	+3.0	+4.4	+11.1	+32.2
N. C.....	25,700	107,000	80,700	2,587,000	100.60	24.20	+.8	+1.2	-1.4	+2.1
N. Dak.....	2,100	8,500	6,400	384,000	181.95	45.45	+2.1	+2.8	+9.1	+22.9
Ohio 3/.....	45,200	189,000	143,000	6,263,000	138.65	33.15	+.5	+.7	+.5	+13.5
Okla. 3/.....	20,900	82,100	61,800	2,862,000	136.95	34.85	+1.7	+1.5	+8.9	+17.1
Oreg. 3/.....	8,500	34,000	24,600	1,333,000	156.65	39.15	+5.2	+3.9	+2.5	+6.2
Pa. 3/.....	58,300	252,000	186,000	9,289,000	159.30	36.90	+3.5	+3.5	-3.3	+10.7
P. R.....	42,500	178,000	141,000	747,000	17.55	4.20	+.1	+.8	-7.1	-5.2
R. I. 3/.....	6,500	25,600	18,900	1,057,000	161.90	41.35	+1.7	+1.9	+9.3	+20.9
S. C.....	6,400	25,100	20,300	400,000	62.10	15.95	-.1	-.2	-7.7	-3.2
S. Dak.....	3,400	12,600	9,500	468,000	138.80	37.10	+1.2	+1.7	+7.5	+22.6
Tenn.....	21,100	85,800	66,100	2,257,000	106.90	26.30	+2.0	+1.7	+5.9	+18.2
Tex.....	22,900	103,000	78,100	2,190,000	95.85	21.25	+1.6	+1.4	+8.7	+15.7
Utah 3/.....	5,600	22,300	16,200	818,000	146.50	36.65	+4.2	+5.0	+1.3	+10.9
Vt.....	1,600	6,200	4,600	181,000	112.35	29.20	+1.2	+1.9	+12.7	+11.5
V. I.....	340	1,300	1,100	26,800	79.35	20.35	-1.3	-.3	+3.6	+12.5
Va.....	11,900	50,900	39,300	1,425,000	120.00	28.00	+2.5	+2.9	+9.3	+25.6
Wash. 3/.....	14,500	56,900	41,200	2,293,000	158.25	40.30	+10.1	+9.0	-6.9	+3.8
W. Va. 3/.....	20,800	97,500	69,400	2,326,000	111.60	23.85	-.9	(5/)	-9.0	-5.5
Wis. 3/.....	12,300	49,400	37,600	2,229,000	181.20	45.15	+4.9	+1.1	+18.2	+22.0
Wyo.....	1,200	4,400	3,400	159,000	136.20	36.20	+.7	+.1	+10.5	+10.9

1/ All data subject to revision. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Includes data on unemployed-parent segment; see table 8. 4/ Data for October; November and December data not received. 5/ Decrease of less than 0.05 percent. 6/ Estimated. 7/ Increase of less than 0.05 percent.

Table 8. Aid to families with dependent children, unemployed-parent segment: Recipients and payments to recipients, by State, December 1966[1]

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
		Total 2/	Children	Total	Average per--		November 1966 in--		December 1965 in--	
					Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total.....	55,200	326,000	223,000	$11,909,000	$215.75	$36.50	+12.8	+16.7	-4.8	+3.8
Ariz.....	5	33	23	13,300	(3/)	(3/)	(3/)	(3/)	(4/)	(4/)
Calif.....	20,400	121,000	83,100	4,684,000	229.45	38.60	+19.9	+27.6	+19.8	+21.9
Colo.....	860	5,200	3,500	190,000	219.60	36.45	+20.2	+23.6	(4/)	(4/)
Conn.....	370	2,300	1,600	88,500	241.70	39.10	-1.4	+8.5	-48.5	-46.3
Del.....	180	1,000	700	27,400	154.20	26.60	+30.2	+18.8	-12.0	-14.1
Hawaii.....	300	1,900	1,300	67,000	223.95	36.00	+4.7	+1.7	+5.9	+11.3
Ill.....	2,600	17,600	12,400	687,000	259.40	39.05	-1.6	+1.6	-34.9	-31.5
Kans.....	190	1,200	840	40,700	210.00	33.45	+4.7	-5.5	-37.8	-36.9
Md.....	370	2,200	1,400	64,700	175.90	29.90	+40.0	+38.8	-19.7	-14.2
Mass.....	500	2,900	2,000	162,000	325.95	55.95	+8.8	+24.7	-12.6	+1.1
Mich. 5/.....	1,400	9,100	6,300	266,000	191.65	29.40	---	---	---	---
Nebr.....	51	350	250	7,900	155.60	22.65	-.3	+11.1	(4/)	(4/)
N. Y.....	11,900	66,600	45,500	2,997,000	252.15	45.00	+9.1	+9.4	-7.3	+9.4
Ohio.....	2,400	14,800	10,300	454,000	192.15	30.75	+.4	+.3	-34.0	-26.2
Okla.....	330	2,000	1,400	62,000	189.70	30.70	+23.1	+16.9	+689.8	+717.4
Oreg.....	1,100	6,400	4,200	229,000	212.00	36.10	+35.5	+43.5	+16.6	+17.4
Pa.....	2,600	14,800	9,800	430,000	167.45	29.10	+27.6	+27.8	-32.0	-25.3
R. I.....	300	1,800	1,200	59,200	193.95	33.20	+13.6	+11.2	+1.0	+16.4
Utah.....	840	4,900	3,200	105,000	124.25	21.25	+10.9	+15.6	-12.1	-2.4
Wash.....	1,300	7,400	4,900	232,000	182.80	31.20	+108.6	+116.5	-26.4	-15.5
W. Va.....	6,900	40,700	27,500	961,000	138.65	23.55	-.5	-.2	-15.5	-14.0
Wis.....	360	1,900	1,300	83,800	231.60	44.35	-9.7	-6.2	(4/)	(4/)

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision.
2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Average payment not computed on fewer than 50 families; percentage change on fewer than 100 recipients. 4/ No program in operation in December 1965. 5/ Data for September; October, November, and December data not received.

Table 9. Aid to families with dependent children: Recipients and money payments to recipients under community work and training programs, by State, December 1966[1]

State	Number of families with an adult on work and training programs	Number of recipients				Money payments to recipients			
		Total 2/	Adults		Children	Total	For work performed on work and training programs	Average per family	
			On work and training programs	Other				Total	For work performed on work and training programs
Total.....	14,600	85,700	14,800	12,400	58,600	$2,535,000	$1,812,000	$173.10	$123.70
Calif.....	3,800	22,500	4,000	3,100	15,400	847,000	351,000	220.40	91.25
Colo.....	320	2,000	320	320	1,400	75,700	36,100	233.60	111.50
Ill.....	640	3,900	640	490	2,800	151,000	114,000	236.55	179.65
Kans.....	60	390	60	59	270	16,900	5,200	281.50	86.95
Md.....	22	120	22	22	73	3,900	2,400	(3/)	(3/)
Mich.....	(4/)	(4/)	(4/)	(4/)	(4/)	(4/)	(4/)	---	---
Ohio.....	2,000	11,000	2,000	1,200	7,800	295,000	226,000	148.50	113.90
Oreg.....	310	1,800	310	280	1,200	67,500	34,600	219.70	112.85
Pa.....	280	1,600	280	280	1,000	64,900	45,100	234.30	162.70
Wash.....	240	1,500	240	240	1,000	48,000	30,900	198.35	127.75
W. Va.....	6,900	40,800	6,900	6,400	27,500	961,000	961,000	138.65	138.65
Wis.....	21	120	21	20	83	5,300	5,300	(3/)	(3/)

1/ Represents data for community work and training programs under plans for such programs submitted under Section 409 of Social Security Act. These data are included in data for the total program and for the unemployed-parent segment. All data subject to revision.
2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Average payment not computed on base of fewer than 50 families. 4/ Data not received.

Table 10. Aid to families with dependent children receiving foster care: Recipients and payments for foster care, by State, December 1966[1]

State	Number of--				Payments for foster care			
	Children receiving foster care			Families from which children were removed	Total amount	Average per child	In foster homes	In institutions
	Total	In foster homes	In institutions					
Total.....	7,800	2/ 6,200	2/ 370	3,400	$619,000	$79.00	2/ $446,000	2/ $58,900
Ala.....	0	0	0	0	0	---	0	0
Alaska.....	72	72	0	32	8,000	111.30	8,000	0
Ariz.....	280	280	0	110	13,300	48.25	13,300	0
Calif.....	1,500	1,300	140	740	141,000	95.35	113,000	27,900
Ill.....	1,200	(2/)	(2/)	550	114,000	91.90	(2/)	(2/)
Ind.....	160	160	0	52	6,300	39.25	6,300	0
Kans.....	110	100	2	49	11,800	111.15	11,500	320
Ky.....	39	39	0	10	2,700	(3/)	2,700	0
La.....	730	680	57	300	58,200	79.40	50,700	7,500
Md.....	1,100	1,100	56	370	85,900	76.90	80,000	5,900
Mich.....	(4/)	(4/)	(4/)	(4/)	(4/)	---	(4/)	(4/)
Minn.....	210	170	33	110	20,300	97.95	12,300	7,900
Mo.....	99	99	0	27	5,500	55.60	5,500	0
Nebr.....	46	46	0	25	2,600	(3/)	2,600	0
N. Mex.....	77	77	0	12	4,400	57.60	4,400	0
N. C.....	26	26	0	9	1,500	(3/)	1,500	0
Okla.....	360	360	0	270	18,500	51.65	18,500	0
Oreg.....	130	130	0	60	8,600	67.40	8,600	0
Tenn.....	470	440	35	160	32,300	68.65	30,300	2,000
Utah.....	210	210	0	98	12,700	61.50	12,700	0
Va.....	43	43	0	14	1,900	(3/)	1,900	0
Wash.....	550	550	0	250	36,200	65.55	36,200	0
W. Va.....	190	170	20	70	15,000	77.95	13,200	1,900
Wis.....	200	190	19	100	17,900	87.30	12,400	5,500

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision. 2/ Excludes Illinois; breakdown not available. 3/ Average payment not computed on base of fewer than 50 children. 4/ Data not received.

Table 11. General assistance: Recipients and payments to recipients, by State, December 1966[1]

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of--		Payments to recipients			Percentage change from--			
				Average per--		November 1966 in--		December 1965 in--	
	Cases	Recipients	Total amount	Case	Recipient	Number of recipients	Amounts	Number of recipients	Amount
Total 2/	302,000	663,000	$24,186,000	$80.10	$36.50	+8.4	+7.5	-2.1	+13.0
Ala.	84	84	1,100	13.25	13.25	(3/)	(3/)	(3/)	(3/)
Alaska	210	720	12,000	57.85	16.65	+20.0	+30.5	+25.5	+49.0
Ariz.	2,100	5,200	114,000	54.85	21.75	+12.3	+5.8	-16.5	-6.6
Ark.	410	1,500	6,700	16.40	4.50	+30.9	+24.4	+8.4	+16.9
Calif.	26,100	45,500	1,876,000	72.00	41.20	+7.4	+5.5	+18.4	+47.7
Colo.	1,300	4,700	55,400	41.55	11.70	+15.7	+11.5	+3.1	-5.7
Conn.	4/ 4,400	4/ 12,500	4/ 378,000	86.70	30.20	+5.7	+13.3	-1.6	+9.6
Del.	1,400	2,700	76,100	54.50	28.10	+3.8	+3.1	+8.9	+7.7
D. C.	1,000	1,100	78,900	77.85	72.70	+3.9	+3.8	+17.8	+21.6
Fla. 5/	7,900	(6/)	239,000	---	---	---	---	---	---
Ga.	2,500	6,600	90,900	35.90	13.75	+13.8	+8.4	+2.2	+16.2
Guam 7/	22	27	830	(3/)	(3/)	---	---	---	---
Hawaii	1,100	1,900	104,000	91.45	54.20	+4.9	+4.4	+31.0	+8.1
Ill.	20,000	46,200	1,782,000	89.00	38.55	+8.7	+11.4	-6.5	-3.7
Iowa 5/	3,100	7,400	131,000	---	---	---	---	---	---
Kans.	2,400	5,800	211,000	86.15	36.40	+8.9	+9.5	-14.0	+4.0
Ky.	1,300	4,500	64,700	47.95	14.35	+18.0	+23.9	+27.1	+48.5
La.	6,200	6,800	321,000	51.85	47.15	+.3	-1.5	-19.6	-20.0
Maine	2,100	6,600	105,000	49.35	15.95	+20.4	+30.6	-26.2	-23.4
Md.	8,600	10,000	679,000	79.05	68.10	+4.5	+2.8	+7.0	+5.5
Mass.	7,800	16,000	671,000	35.85	42.05	+8.4	+5.1	+.9	+14.4
Mich. 8/	15,400	52,800	1,526,000	---	---	---	---	---	---
Minn.	6,200	19,200	535,000	85.90	27.90	+9.5	+6.2	-16.0	-17.0
Miss.	1,200	1,500	20,800	17.65	14.10	+3.1	+.2	+5.4	+3.1
Mo.	9,500	12,100	643,000	67.90	53.15	+4.5	+1.8	-4.6	-.8
Mont.	1,200	3,400	64,900	56.15	18.90	+14.7	+20.0	-7.1	-4.3
Nev.	370	880	28,400	76.85	32.40	+6.8	+71.5	-19.7	+20.7
N. H.	760	2,600	52,300	68.50	20.50	+20.3	+14.1	-1.8	-3.6
N. J. 9/	10,400	33,100	1,340,000	129.25	40.50	+13.6	+9.6	+10.0	+16.7
N. Mex.	310	730	12,700	41.25	17.50	+21.7	+8.5	+19.1	+2.4
N. Y. 10/	59,700	133,000	6,837,000	114.50	51.55	+4.6	+6.5	+18.1	+44.9
N. C.	1,800	4,900	45,100	24.80	9.15	+19.1	+10.9	-4.9	-.7
N. Dak.	360	1,600	23,700	66.30	14.90	+50.8	+53.0	-4.7	-4.2
Ohio	22,200	64,300	1,990,000	89.80	30.95	+13.5	+9.9	-16.4	+14.3
Okla.	6,200	(6/)	74,200	12.05	---	---	-4.6	---	-25.1
Oreg.	3,900	(6/)	209,000	53.30	---	---	+21.9	---	-5.6
Pa.	28,100	35,200	2,109,000	75.05	59.95	+3.2	+2.6	-9.6	-4.2
P. R.	1,200	1,200	10,500	8.90	8.90	-38.3	-38.1	-11.4	-8.0
R. I.	3,100	8,000	236,000	76.35	29.40	+16.3	+27.3	+17.5	+21.8
S. C.	1,200	1,300	35,400	30.55	27.10	-3.5	-1.9	-4.5	-3.0
S. Dak.	340	1,000	11,000	31.90	10.50	+33.4	+40.1	-22.5	-3.3
Tenn.	1,700	2,800	52,400	30.30	19.00	+9.0	+11.4	-4.3	+22.5
Tex. 11/	8,400	(6/)	256,000	---	---	---	---	---	---
Utah	680	810	49,300	72.20	60.55	+13.2	+13.6	-11.1	+3.4
Vt. 11/	1,000	(6/)	34,000	---	---	---	---	---	---
V. I.	190	200	7,500	38.95	36.80	+4.1	+8.0	-9.0	-6.4
Va.	2,800	6,600	155,000	54.60	23.40	-10.2	-4.5	-7.1	+6.1
Wash.	8,100	15,300	634,000	77.85	41.40	+21.7	+16.3	+21.1	+16.3
W. Va.	1,800	3,300	70,500	38.10	21.50	+12.4	+7.3	+23.1	+18.2
Wis.	4,200	11,900	334,000	79.65	28.15	+7.2	+11.9	-36.0	-39.1
Wyo.	390	1,500	28,500	73.00	18.90	+23.7	+25.3	-9.3	-16.8

1/ All data subject to revision. 2/ Partly estimated; does not represent sum of State figures because totals exclude for New Jersey an estimated number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services; recipient count also includes an estimate for States not reporting such data. Excludes Idaho, Indiana, and Nebraska; data not available. 3/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 4/ About 13 percent of this total is estimated. 5/ Partly estimated. 6/ Data not available. 7/ Data for October; November and December data not received. 8/ Estimated. 9/ Includes an unknown number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services. 10/ Included an unknown number of cases and persons receiving only medical care. 11/ Estimated on basis of reports from sample of local jurisdictions.

Table 12. Medical assistance: Number of persons on whose behalf payments were made and amount of such payments, December 1966[1]

State	Persons on whose behalf payments were made	Payments
Total 26 States 2/	(3/)	$159,184,000
Total, 13 States reporting completely	838,000	$89,367,000
Calif.	(3/)	35,944,000
Conn.	(3/)	2,739,000
Del.	(3/)	16,400
Hawaii	5,700	439,000
Idaho	4,200	454,000
Ill.	178,000	6,801,000
Ky.	(3/)	2,045,000
La.	(3/)	2,459,000
Maine	(3/)	850,000
Md.	(3/)	3,135,000
Mass.	(3/)	9,361,000
Mich.	(3/)	7,145,000
Minn.	60,600	5,490,000
Nebr.	(3/)	1,652,000
N. Mex.	(3/)	670,000
N. Y.	301,000	51,168,000
N. Dak.	6,200	609,000
Ohio	62,100	2,403,000
Okla.	48,700	6,304,000
Pa.	97,400	9,389,000
R. I.	20,300	837,000
Utah	9,100	681,000
Vt.	5,600	299,000
Wash.	(3/)	2,981,000
W. Va.	(3/)	820,000
Wis.	39,100	4,495,000

1/ Program initiated January 1966 under Public Law 89-97. Data based primarily on bills paid during the month and are subject to fluctuations unrelated to provision of medical services. All data subject to revision.
2/ Data not reported by Puerto Rico and Virgin Islands.
3/ Number of recipients not reported by California, Connecticut, Delaware, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Nebraska, New Mexico, Washington, and West Virginia.

2/ Number of recipients not reported by California, Connecticut, Delaware, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Nebraska, New Mexico, Washington, and West Virginia.

Table 13. Medical assistance for the aged: Number of persons on whose behalf payments were made and amount of such payments, December 1966[1]

State	Persons on whose behalf payments were made	Payments	Percentage change from--			
			November 1966 in--		December 1965 in--	
			Number	Amount	Number	Amount
Total.....	48,400	$5,087,000	+1.7	-3.0	-82.7	-90.4
Ala.....	45	3,400	(2/)	(2/)	-80.7	-95.4
Ariz.....	140	1,800	+15.7	+54.5	(3/)	(3/)
Ark. 4/.....	530	60,400	-8.5	-3.0	-83.2	-70.3
Colo.....	5,800	5/ 1,108,000	-8.2	-7.2	+10.0	+6.5
D. C.....	300	168,000	0	+2.4	-40.7	+40.0
Fla. 4/ 6/.....	32	11,700	(2/)	(2/)	-94.5	-93.3
Guam.....	(7/)	(7/)	---	---	---	---
Ind.....	1,500	218,000	+2.5	-11.7	+56.2	+9.6
Iowa.....	4,600	403,000	-2.3	-.6	-.9	+3.9
Kans. 4/.....	3,900	5/ 528,000	+.2	+2.1	+11.8	-1.7
Mont.....	1,800	212,000	+8.5	+17.7	+6.3	-34.5
Nev.....	420	5/ 146,000	+7.1	+1.9	-26.3	+73.2
N. H.....	1,800	27,200	-17.0	-28.0	-16.7	-78.4
N. J.....	6,100	5/ 1,524,000	-2.7	-9.7	+3.9	+3.3
N. C.....	3,700	103,000	+5.3	-11.2	+34.5	-69.4
Oreg.....	1,300	91,500	-5.3	+9.2	-69.9	-85.1
S. C.....	17	4,400	(2/)	(2/)	-98.7	-98.1
S. Dak.....	1,400	229,000	+121.6	+144.2	+3.7	+81.9
Tenn.....	11,800	170,000	+13.1	+6.6	+21.0	-44.3
Va.....	3,300	76,600	-10.0	-12.2	-17.4	-72.0
Wyo.....	(8/)	(8/)	---	---	---	---

1/ All data subject to revision. Data based primarily on bills paid during the month and are subject to fluctuations unrelated to provision of medical services. 2/ Percentage change not computed on fewer than 100 recipients. 3/ No program in operation in December 1965. 4/ Represents medical assistance for the aged under program for aid to the aged, blind, or disabled and medical assistance for the aged. 5/ Excludes small amount of money payments not subject to Federal participation. 6/ Program discontinued prior to December 1966. Data represent payments made for care furnished recipients prior to that month. 7/ Program in operation, no payments made in October 1966; no report received for November and December. 8/ Program in operation, no payments made in December 1966.

Table 14. Amount of vendor payments for medical care for recipients of public assistance, by program and State, December 1966[1]

State	Total 2/	Percentage change from--		Medical assistance	Medical assistance for the aged	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children	General assistance 3/
		November 1966	December 1965							
Total	3/ $191,113,000	-1.1	+48.3	$159,184,000	$5,087,000	$13,789,000	$238,000	$3,088,000	$2,939,000	2/ $6,788,000
Ala.	1,027,000	+3.5	-31.6	---	3,400	929,000	4,000	89,800	540	---
Alaska 4/	152,000	+50.6	+15.7	---	---	36,400	370	15,400	65	99,600
Ariz.	148,000	+14.6	+78.9	---	1,800	146,000	---	---	---	---
Ark. 4/	1,364,000	+.4	-5.8	---	60,400	898,000	23,100	287,000	54,600	40,400
Calif.	35,944,000	-16.9	+103.3	35,944,000	---	---	---	---	---	---
Colo.	1,847,000	-5.2	-11.3	---	5/ 1,108,000	378,000	3,800	132,000	167,000	57,000
Conn.	2,739,000	+.3	+18.6	2,739,000	---	---	---	---	---	---
Del.	16,400	+15.3	-56.5	16,400	---	---	---	---	---	---
D. C.	173,000	+.4	-17.1	---	168,000	480	220	1,300	2,100	500
Fla. 4/	1,895,000	-1.1	+22.8	---	11,700	1,519,000	16,400	236,000	112,000	---
Ga. 4/	1,495,000	+9.2	+3.5	---	---	1,152,000	17,500	256,000	69,000	---
Guam 6/	1,700	---	---	---	(7/)	---	---	200	1,500	---
Hawaii	459,000	-51.6	+.8	439,000	---	---	---	---	---	20,700
Idaho	454,000	+7.4	-8.1	454,000	---	---	---	---	---	---
Ill.	7,462,000	-2.9	+8.6	6,801,000	---	---	---	---	---	661,000
Ind.	1,663,000	+6.2	-5.7	---	218,000	828,000	60,600	286,000	331,000	---
Iowa.	1,954,000	-.7	+.8	---	403,000	1,080,000	20,000	86,200	173,000	8/ 191,000
Kans. 4/	1,396,000	+11.2	-12.6	---	5/ 528,000	258,000	6,700	169,000	285,000	149,000
Ky.	2,045,000	+12.7	+19.5	2,045,000	---	---	---	---	---	---
La.	2,465,000	+29.0	+2.8	2,459,000	---	---	---	---	---	6,000
Maine	924,000	+40.0	+47.9	850,000	---	---	---	---	---	73,900
Md.	3,135,000	+20.1	+87.7	3,135,000	---	---	---	---	---	---
Mass.	9,613,000	+8.8	+9.0	9,361,000	---	---	---	---	---	251,000
Mich.	7,772,000	-10.0	+90.8	7,145,000	---	---	---	---	---	627,000
Minn.	5,730,000	+1.0	+13.6	5,490,000	---	---	---	---	---	240,000
Miss.	37,200	+19.4	-72.7	---	---	35,800	1,400	---	---	---
Mo.	1,067,000	-.7	-16.6	---	---	885,000	---	88,200	67,500	26,100
Mont.	615,000	+2.9	-17.1	---	212,000	50,400	340	580	33	351,000
Nebr.	1,652,000	+11.0	+6.6	1,652,000	---	---	---	---	---	---
Nev.	216,000	+6.4	-26.7	---	5/ 146,000	22,300	1,100	---	16,800	30,300
N. H.	208,000	-5.1	-30.1	---	27,200	101,000	5,400	26,500	47,500	---
N. J.	2,577,000	-6.2	-4.4	---	5/ 1,524,000	113,000	11,100	310,000	381,000	238,000
N. Mex. 4/	678,000	+50.6	+34.8	670,000	---	---	---	---	---	8,000
N. Y.	51,168,000	+.1	+164.6	51,168,000	---	---	---	---	---	---
N. C.	1,420,000	+2.7	-7.1	---	103,000	358,000	13,900	513,000	322,000	110,000
N. Dak.	621,000	+4.4	-11.0	609,000	---	---	---	---	---	12,000
Ohio	3,446,000	-32.3	-19.1	2,403,000	---	---	---	---	---	1,043,000
Okla.	6,304,000	+31.3	+155.3	6,304,000	---	---	---	---	---	---
Oreg.	1,095,000	+7.5	-7.3	---	91,500	550,000	10,800	182,000	181,000	78,400
Pa.	9,389,000	+36.2	+40.5	9,389,000	---	---	---	---	---	---
P. R.	(3/)	---	---	(3/)	---	---	---	---	---	---
R. I.	927,000	+7.6	-7.3	837,000	---	---	---	---	---	90,800
S. C.	584,000	+8.7	-24.5	---	4,400	432,000	20,800	96,900	19,300	10,800
S. Dak.	470,000	+14.8	-9.8	---	229,000	116,000	360	31,400	---	93,600
Tenn.	984,000	-3.8	+.8	---	170,000	687,000	2,400	53,600	70,500	---
Tex.	3,549,000	-.2	+35.9	---	---	2,841,000	2,100	143,000	563,000	---
Utah	683,000	-1.2	+5.9	681,000	---	---	---	---	---	2,300
Vt.	299,000	-7.5	-2.0	299,000	---	---	---	---	---	---
V. I.	(3/)	---	---	(3/)	---	---	---	---	---	---
Va.	632,000	+.8	-19.5	---	76,600	335,000	14,600	127,000	53,200	25,500
Wash.	3,325,000	-8.9	-4.8	2,981,000	---	---	---	---	---	344,000
W. Va.	851,000	+30.9	+1.4	820,000	---	---	---	---	---	31,600
Wis.	4,676,000	-7.8	-.1	4,495,000	---	---	---	---	---	181,000
Wyo.	122,000	+4.5	-5.7	---	(9/)	35,300	970	16,800	19,800	49,500

1/ Amounts represent primarily bills paid during the month and therefore are subject to fluctuations unrelated to provision of medical services. All data subject to revision. 2/ Data incomplete for general assistance. Some States do not report these data and for some the data represent only partial reporting. The total includes an estimated amount for these States. 3/ Data not reported by Puerto Rico and Virgin Islands. 4/ Except for aid to families with dependent children and general assistance, data represent payments for recipients of the specified types of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 5/ Excludes small amount of money payments not subject to Federal participation. 6/ Data for October; November and December data not received. 7/ Program in operation; no payments made in October 1966. 8/ Partly estimated. 9/ No payments made in December 1966.

Work Experience and Training Program under Title V of the Economic Opportunity Act of 1964, As Amended

DECEMBER 1966

As of the end of December 1966, the Title V Work Experience and Training Program had funded a total of 328 projects of which 43 were State administrative, 13 local administrative, and 272 work experience and training. Twenty-four (including the 13 local administrative projects) of the 328 projects were either phased out or were not renewed for the second year of operation, while 2 of the remaining 304 projects were to begin operating on or after January 1, 1966. Of the remaining 302 projects that were in operation, 40 were State administrative and 262 were work experience and training. These 262 projects were located in 49 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

Of the 70,645 trainees on work experience and training projects, 31,807 were male and 38,838 female. Dependents of these trainees totaled 292,417. During the month, 775 cases were closed, which resulted in a monthly rate of reduction in assistance payments of $149,575.

Table 15. Work experience and training: Status of projects, December 1966

Item	Number of projects			
	Total funded	Phased out or not renewed	Not yet in operation	In operation
Total	328	24	2	302
State administrative	43	2	1	40
Local administrative	13	13	0	0
Work experience and training	272	[1] 9	1	262
Counties and independent cities covered	751	16	1	734
Number of training spaces authorized	86,957	[2] 4,180	50	82,727
States and jurisdictions covered	[3] 53	-	1	[4] 52

[1]Includes projects that were merged. [2]This figure includes training spaces that were in phased out projects and also training spaces in projects that are in the process of being phased out. [3]Excludes Alabama. [4]Excludes Alabama and Guam.

Table 16. Work experience and training: Number of trainees by sex, and number of their dependents (adults and children), by State, December 1966

State	Number aided						
	Total	Trainees			Dependents of trainees		
		Total	Male	Female	Total	Adults	Children
Total...	363,062	70,645	31,807	38,838	292,417	41,397	251,020
Ala.....	(1/)	(1/)	(1/)	(1/)	(1/)	(1/)	(1/)
Alaska.....	152	30	5	25	122	21	101
Ariz.....	1,400	330	83	247	1,070	103	967
Ark.....	7,000	1,438	554	884	5,562	743	4,819
Calif.....	19,576	4,370	1,927	2,443	15,206	2,063	13,143
Colo.....	7,468	1,375	869	506	6,093	873	5,220
Conn.....	5,224	1,223	265	958	4,001	249	3,752
Del.....	227	32	29	3	195	28	167
D. C.....	5,010	926	269	657	4,084	1,173	2,911
Fla.....	5,851	1,158	250	908	4,693	281	4,412
Ga.....	3,207	638	142	496	2,569	135	2,434
Guam.....	(1/)	(1/)	(1/)	(1/)	(1/)	(1/)	(1/)
Hawaii.....	435	87	70	17	348	57	291
Idaho.....	1,199	287	104	183	912	111	801
Ill.....	2,556	833	329	504	1,723	151	1,572
Ind.....	2,161	499	9	490	1,662	14	1,648
Iowa	3,204	803	153	650	2,401	164	2,237
Kans.....	148	34	6	28	114	12	102
Ky.....	32,152	5,630	5,630	0	26,522	5,460	21,062
La.....	5,807	1,132	314	818	4,675	464	4,211
Maine.....	1,553	334	211	123	1,219	209	1,010
Md.....	4,449	909	206	703	3,540	299	3,241
Mass. 2/.....	10,204	2,709	644	2,065	7,495	416	7,079
Mich. 3/.....	13,946	3,236	716	2,520	10,710	781	9,929
Minn.....	7,367	1,786	698	1,088	5,581	686	4,895
Miss.....	18,669	3,318	1,072	2,246	15,351	1,318	14,033
Mo.....	4,504	944	146	798	3,560	237	3,323
Mont.....	697	155	49	106	542	50	492
Nebr.....	1,293	251	40	211	1,042	0	1,042
Nev.....	1,703	400	210	190	1,303	180	1,123
N. H.....	166	55	10	45	111	10	101
N. J.....	6,943	1,330	563	767	5,613	668	4,945
N. Mex.....	3,806	846	233	613	2,960	222	2,738
N. Y.....	10,638	2,362	1,058	1,304	8,276	1,261	7,015
N. C.....	1,465	351	83	268	1,114	52	1,062
N. Dak.....	1,115	150	141	9	965	139	826
Ohio.....	12,881	2,343	1,033	1,310	10,538	2,134	8,404
Okla.....	4,610	893	459	434	3,717	661	3,056
Oreg. 2/.....	5,900	1,564	460	1,104	4,336	405	3,931
Pa.....	7,648	1,727	500	1,227	5,921	518	5,403
P. R.....	59,100	9,582	3,013	6,569	49,518	7,512	42,006
R. I.....	2,607	773	183	590	1,834	108	1,726
S. C.....	1,233	222	24	198	1,011	97	914
S. Dak.....	1,664	313	220	93	1,351	213	1,138
Tenn.....	4,980	926	320	606	4,054	367	3,687
Tex.....	3,401	787	331	456	2,614	426	2,188
Utah.....	1,751	423	97	326	1,328	123	1,205
Vt.....	696	195	34	161	501	28	473
V. I.....	172	51	4	47	121	5	116
Va.....	1,107	193	189	4	914	187	727
Wash.....	4,665	1,114	213	901	3,551	251	3,300
W. Va.....	52,302	7,937	7,183	754	44,365	9,203	35,162
Wis.....	4,982	1,342	171	1,171	3,640	174	3,466
Wyo.....	2,068	299	285	14	1,769	355	1,414

1/ No WEAT projects in operation. 2/ Data for November; December data not received. 3/ Data for August; September, October, November, and December data not received.

Table 17. Work experience and training: Monthly reduction in expenditures for public assistance payments resulting from employment of trainees, by State, December 1966

State	Amount of monthly reductions				
	Total	In Federally aided public assistance cases			In general assistance cases
		Total	Closed cases	Reduced payment	
Total.....	$ 205,506	$ 190,983	$ 149,575	$ 41,408	$ 14,523
Ala.....	(1/)	(1/)	(1/)	(1/)	(1/)
Alaska.....	0	0	0	0	0
Ariz.....	622	622	622	0	0
Ark.....	640	640	439	201	0
Calif.....	16,124	16,124	7,629	8,495	0
Colo.....	4,028	2,904	279	2,625	1,124
Conn.....	5,368	5,056	4,128	928	312
Del.....	0	0	0	0	0
D. C. 2/....	0	0	0	0	0
Fla.....	249	249	234	15	0
Ga.....	531	531	531	0	0
Guam.....	(1/)	(1/)	(1/)	(1/)	(1/)
Hawaii.....	432	247	247	0	185
Idaho.....	348	348	348	0	0
Ill.....	3,942	2,764	1,842	922	1,178
Ind.....	0	0	0	0	0
Iowa.....	3,542	3,455	1,793	1,662	87
Kans.....	374	374	0	374	0
Ky. 2/.....	0	0	0	0	0
La.....	1,401	1,401	1,052	349	0
Maine.....	0	0	0	0	0
Md.....	4,398	4,334	3,725	609	64
Mass. 3/....	16,182	15,758	11,200	4,558	424
Mich. 4/....	11,227	11,227	10,766	461	0
Minn.....	10,679	2,878	2,839	39	7,801
Miss.....	1,183	1,183	679	504	0
Mo.....	1,038	1,038	588	450	0
Mont.....	147	147	147	0	0
Nebr.....	1,113	1,113	1,113	0	0
Nev.....	0	0	0	0	0
N. H.....	0	0	0	0	0
N. J.....	5,745	4,744	2,728	2,016	1,001
N. Mex.....	481	481	421	60	0
N. Y.....	10,120	9,835	7,190	2,645	285
N. C.....	0	0	0	0	0
N. Dak.....	0	0	0	0	0
Ohio.....	12,490	12,431	5,543	6,888	59
Okla.....	1,393	1,393	1,355	38	0
Oreg. 3/....	5,293	4,931	3,930	1,001	362
Pa.....	5,535	5,535	4,886	649	0
P. R.....	2,211	2,211	1,994	217	0
R. I.....	1,180	930	930	0	250
S. C.....	627	627	583	44	0
S. Dak.....	2,510	1,189	527	662	1,321
Tenn.....	765	765	765	0	0
Tex.....	68	68	0	68	0
Utah.....	6,218	6,218	5,664	554	0
Vt.....	282	282	140	142	0
V. I.....	0	0	0	0	0
Va.....	0	0	0	0	0
Wash.....	6,054	6,054	5,539	515	0
W. Va.....	55,389	55,389	53,790	1,599	0
Wis.....	5,577	5,507	3,389	2,118	70
Wyo.....	0	0	0	0	0

1/ No WE&T projects in operation. 2/ Trainees were unemployed or in the marginal income group but were neither recipients of public assistance or general assistance before Title V training. 3/ Data for November; December data not received. 4/ Data for August; September, October, November, and December data not received.

Table 18. Old-age, survivors, and disability insurance benefits, summary data, December 1966[1]

DATA, DECEMBER 1966

Type of benefit	Benefits awarded in December 1966		Benefits in current-payment status, end of December 1966			Amount of benefits paid 1/ in December 1966 (in thousands)
	Number	Average Amount	Number	Monthly rate (in thousands)	Average Amount	
Total, OASI and DI	413,099	---	---	---	---	$1,720,916
Total, OASI	359,424	---	---	---	---	1,566,848
Monthly benefits, OASI and DI	326,449	---	22,767,252	$1,638,548	---	1,703,060
Monthly benefits, OASI	272,774	---	20,796,930	1,502,863	---	1,548,992
Monthly benefits, DI	53,675	---	1,970,322	135,683	---	154,068
Old-age (retired-worker)	83,270	$89.50	11,658,443	983,338	$84.35	1,006,556
Disability (disabled-worker)	23,518	101.65	1,097,190	107,627	98.09	120,473
Wife's or husband's (OASI and DI)	28,667	41.08	2,860,026	123,262	43.10	129,094
Wife's or husband's (OASI)	21,712	42.72	2,640,467	115,686	43.81	119,856
Wife's or husband's (DI)	6,955	35.95	219,559	7,577	34.51	9,238
Widow's or widower's	27,118	75.96	2,602,015	192,821	74.10	200,541
Parent's	220	82.93	34,540	2,642	76.48	2,827
Transitional noninsured (OASI) 2/	78,606	---	634,313	21,777	---	23,665
Primary	73,716	---	616,487	21,465	34.82	23,291
Wife	4,890	---	17,826	312	17.49	374
Child's (OASI and DI)	76,548	---	3,392,970	175,100	---	186,331
Child's (OASI--total)	53,346	---	2,739,397	154,618	---	161,974
Child's (OASI--life) 3/	12,239	37.04	504,011	16,535	32.81	17,234
Child's (OASI--survivor) 3/	41,107	62.71	2,235,386	138,083	61.77	144,740
Child's (DI)	23,202	32.66	653,573	20,482	31.34	24,357
Mother's	8,502	68.30	487,755	31,983	65.57	33,573
Lump-sum death payments	86,650	4/221.95	---	---	---	17,856

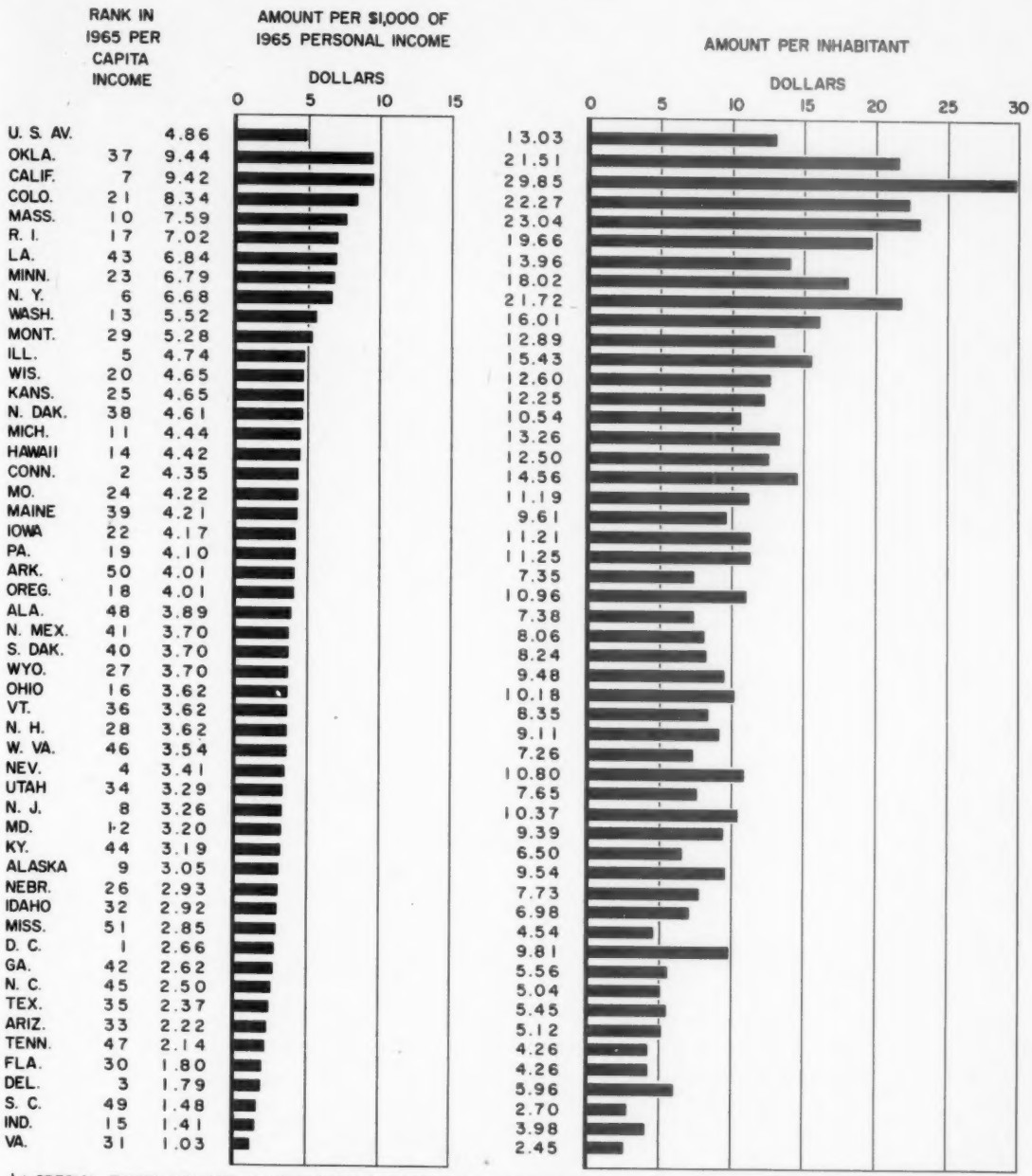
COMPARATIVE DATA

Item	December 1966	November 1966	December 1965
Number of benefits in current-payment status, end of month:			
Total, OASI and DI	22,767,252	22,650,872	20,866,767
Total, OASI	20,796,930	20,697,497	19,127,716
Total, DI	1,970,322	1,953,375	1,739,051
Amount of benefits paid (in thousands):			
Total, OASI and DI	$1,720,916	$1,703,048	$1,607,154
Total, OASI	1,566,848	1,550,331	1,468,063
Total, DI	154,068	152,717	139,091
Number of old-age (retired-worker) benefits:			
Awarded	83,270	83,284	128,123
In current-payment status, end of month	11,658,443	11,629,673	11,100,584
Average old-age (retired-worker) benefit:			
Awarded	$89.50	$88.79	$88.25
In current-payment status, end of month	84.35	84.27	83.92
Number of disability insurance (disabled-worker) benefits:			
Awarded	23,518	21,956	21,069
In current-payment status, end of month	1,097,190	1,088,853	988,074
Average disability insurance (disabled-worker) benefit:			
Awarded	$101.65	$101.09	$101.28
In current-payment status, end of month	98.09	98.07	97.76
Number of persons aged 62 and over receiving monthly benefits, end of month (OASI and DI) 5/	17,570,000	17,468,000	16,132,000
Number of persons aged 65 and over receiving monthly benefits, end of month (OASI and DI) 5/	15,606,000	15,504,000	14,278,000
Assets of trust funds, end of month (in millions):			
OASI	$20,570	$20,569	$18,235
DI	1,739	1,724	1,606
HI (hospital insurance)	944	1,006	---
SMI (supplementary medical insurance)	122	148	---

1/ Exceeds monthly amount of benefits in current-payment status because of the inclusion, in initial payments, of amounts for prior months. Distribution by type of monthly benefit estimated.
2/ Payable to certain noninsured persons aged 72 and over. Payments to such beneficiaries who have less than 3 quarters of coverage are financed from the general fund of the Treasury
3/ Distribution by type of claim for OASI child's benefits estimated.
4/ Average lump sum per worker; there were 80,453 deceased workers represented in the current month's lump-sum awards.
5/ Numbers estimated and shown to the nearest thousand. At the end of December 1966 there were an estimated 1,299,000 women and 665,000 men aged 62-64 receiving monthly benefits

*U. S. GOVERNMENT PRINTING OFFICE : 1967 254-649/10

EXPENDITURES FOR PUBLIC ASSISTANCE 1/ FROM STATE AND LOCAL FUNDS, FISCAL YEAR 1966 2/



1/ SPECIAL TYPES OF PUBLIC ASSISTANCE AND GENERAL ASSISTANCE.

2/ EXCLUDES GUAM, PUERTO RICO, AND VIRGIN ISLANDS; INCOME DATA NOT AVAILABLE.

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